

1802 CERTIFICATE OF DEATH

Reg. Dist. No.

01789

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 537 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Jackson Last Barkley		4. DATE OF DEATH Month February Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) New Castle Co., Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Barkley		14. MOTHER'S MAIDEN NAME Fannie Barkley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Charles Jackson Barkley - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Moderately advanced bilateral pulmonary tbc. DUE TO (c) Diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 22, 1958 , to February 10, 1960 , that I last saw the deceased alive on February 10, 1960 , and that death occurred at 4:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Maculans		DATE SIGNED 2-10-60	
PHYSICIAN'S NAME (Type) Dr. E. M. Maculans, Supt.		Henryton State Hospital Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-1960	22c. NAME OF CEMETERY OR CREMATORY Glass Hill Cem.	22d. LOCATION (City, town, or county) (State) Eden, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley		ADDRESS Salisbury, Md.	
24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1803 CERTIFICATE OF DEATH

Reg. Dist. No.

01790

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brockmont</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield St. Hosp.</u>		d. STREET ADDRESS <u>6435 Brookes Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Irene BOOSE</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis King</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lolly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, Springfield St. Hosp.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involuntary psychic reaction</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>58</u> , to <u>Febr.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-13-</u> 19 <u>60</u> , and that death occurred at <u>8:05 P. M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Konstantin Weber</u> M.D.		ADDRESS (Street, city or town, state) <u>042 street at Short Hill Rd</u>	
DATE SIGNED <u>Spikesville, Md</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>2/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Feb 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1502 CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1804 CERTIFICATE OF DEATH

01791

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 8yrs. 7mos. 26days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 11 Westminster Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lowell Middle Lewis Last Bosley		4. DATE OF DEATH Month February Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1909
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Bosley		14. MOTHER'S MAIDEN NAME Lylia Huntermark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic interstitial bilateral 491X DUE TO bronchopneumonia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-traumatic psychosis, post-traumatic deterioration.			INTERVAL BETWEEN ONSET AND DEATH weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19, 1951 to February 15, 1960 , that (I) (we) last saw the deceased alive on February 15, 1960 , and that death occurred at 3:30 PM on the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 2/15/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 19, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City, town, or county) (State) Black Rock Road, Butler, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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CERTIFICATE OF DEATH

Reg. Dist. No.

01792

1795

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
c. LENGTH OF STAY IN 1b life		d. STREET ADDRESS 202 E. Main Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 E. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Holbrook Bowers		4. DATE OF DEATH Month Day Year February 11 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Holbrook	
14. MOTHER'S MAIDEN NAME Margaret (unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 220-03-6312		17. INFORMANT Address Charles H. Bowers Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute nephritis, Acute myocarditis 590x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 30, 1960 to Feb. 11, 1960 , that I last saw the deceased alive on Feb. 10, 1960 , and that death occurred at 9:25 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Jennette M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 103 E. Main St. Westminster, Md. 2-17-60	
PHYSICIAN'S NAME (Type) W. C. Jennette, M.D.		103 E. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-14-60	22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.	22d. LOCATION (City, town, or county) (State) Pleasant Valley, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Maryland		24a. REC'D BY REGISTRAR DATE FEB 16 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1797

CERTIFICATE OF DEATH

Reg. Dist. No.

01793

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Md.				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 32 Pennsylvania ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francois Joseph Boylan				4. DATE OF DEATH Month Day Year Feb. II 19 60			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/25/85	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labeler		10b. KIND OF BUSINESS OR INDUSTRY canning factory		11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Boylan				14. MOTHER'S MAIDEN NAME Marie Ginnerty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-01-3112		INFORMANT Address sister Mrs Claude Mitten RD#3 Westminster			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10 - , 19 60 , to Feb 11 , 19 60 , that I last saw the deceased alive on Feb 11 , 19 60 , and that death occurred at 8:30 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md. DATE SIGNED 2-11-60							
ACTUAL SIGNATURE James J. Marsh M.D.				PHYSICIAN'S NAME (Type) JAMES T. MARSH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/60		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell ADDRESS Westminster, Md.				24a. REC'D BY REGISTRAR FEB 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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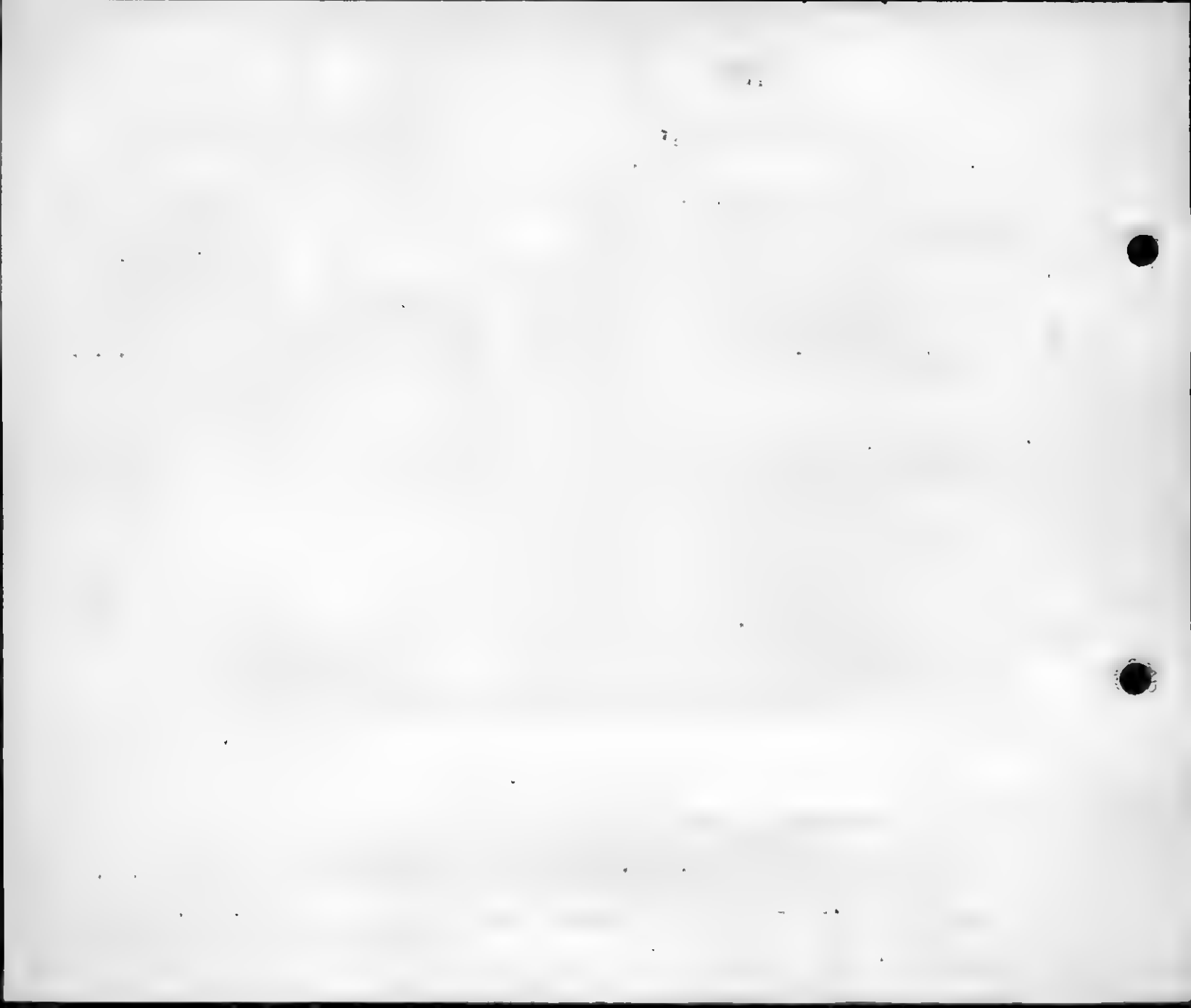
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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) ✓ a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparksville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 2 mos. 7 days				d. STREET ADDRESS 3305 Harford Road, Zone 14			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Surin Field State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nicholas Middle Henry Last Trendel				4. DATE OF DEATH Month February Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 3, 1897	
9. AGE (In years lost birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 2 Days 7		11. IF UNDER 24 HRS. Hours 11 Min 00		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. Transit Co.				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Trendel				14. MOTHER'S MAIDEN NAME Catherine Harold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No - 1918, 1919				16. SOCIAL SECURITY NO 213-05-9014		17. INFORMANT Surin Field Hospital records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depression.							INTERVAL BETWEEN ONSET AND DEATH days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 24, 1959 to February 2, 1960 that (I) (we) last saw the deceased alive on February 79 60 , and that death occurred at 2:25 PM from the causes and on the date stated above							
22a. SIGNATURE Augustus del Campo				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Augustus del Campo, M.D.	
22d. ADDRESS Springfield Hospital, Sparksville, Md.				22e. REGISTRAR'S SIGNATURE Leonard J. Ruck			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2-11-60		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				25a. REC'D BY REGISTRAR DATE FEB 10 '60		25b. REGISTRAR'S SIGNATURE Wm. S. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1805

CERTIFICATE OF DEATH

01795

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>7 mos. 24 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edithsburg</u> <u>Daisy</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Lavinia Stier Brightwell</u>		4. DATE OF DEATH Month Day Year <u>February 18, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1881</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Tob Stier</u>		14. MOTHER'S MAIDEN NAME <u>Eleanora Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with senile brain disease with psychotic reaction.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 24, 1959</u> to <u>Feb. 18, 1960</u> , that (I) (we) last saw the deceased alive on <u>Feb. 18, 1960</u> , and that death occurred at <u>2:55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Agustin del Campo</u>		22b. DATE SIGNED <u>2/18/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Feb. 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Regular Spring Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edithsburg</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Edithsburg</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> c. LENGTH OF STAY IN 1b <u>10 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster Md. Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor P.O.#1</u> d. STREET ADDRESS <u>Medford</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JAMES ALFRED BROTHERS</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>9</u> Year <u>1960</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>Jan 5, 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer & carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>							
13. FATHER'S NAME <u>Solomon Brothers</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Fowler</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-01-0563</u>		17. INFORMANT <u>Mrs. N. A. Entwistle, Union Bridge Rd., Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width:100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> (b) <u>Coronary Sclerosis</u> (c) </td> </tr> <tr> <td colspan="3"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Coronary Sclerosis</u> (c)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Coronary Sclerosis</u> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James T. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-10-60</u>							
EXAMINER'S NAME (Type) <u>James T. Marsh</u>											
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Medford Rural Cemetery</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Myers</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[Faint, illegible handwriting]

1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

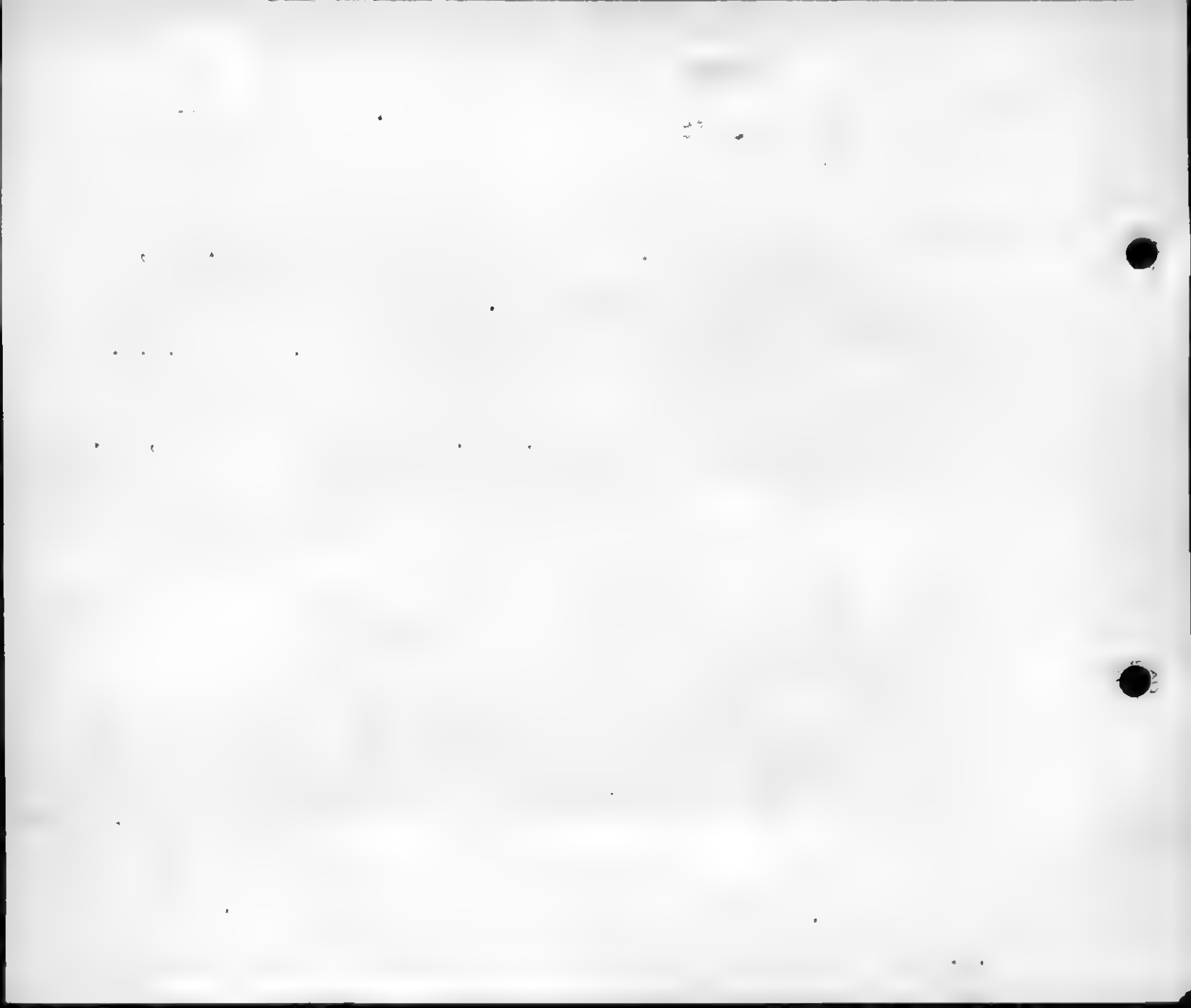
VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01797

1809
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkins	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Golden Age Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle S. Last CARGILL		4. DATE OF DEATH Month FEB. Day 6, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1872
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Baton Rouge, La..		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Landry		14. MOTHER'S MAIDEN NAME Sinah Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Ida. Weber, Ellicott City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO hypertension (c) Myocardial infarction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1960 to Feb 6, 1960 that (I) (we) last saw the deceased alive on Feb 2, 1960 and that death occurred on 3/10 M, from the causes and on the date stated above.			
22a. SIGNATURE Donald H. Martin M.D.		22b. DATE SIGNED Feb. 7, 60	
22c. PHYSICIAN'S NAME (Type) DR. MARTIN		22d. ADDRESS MA	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9, 1960	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town, or county) (State) Carroll Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz,		25a. REC'D BY REGISTRAR Winfield, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE FEB 10 '60	



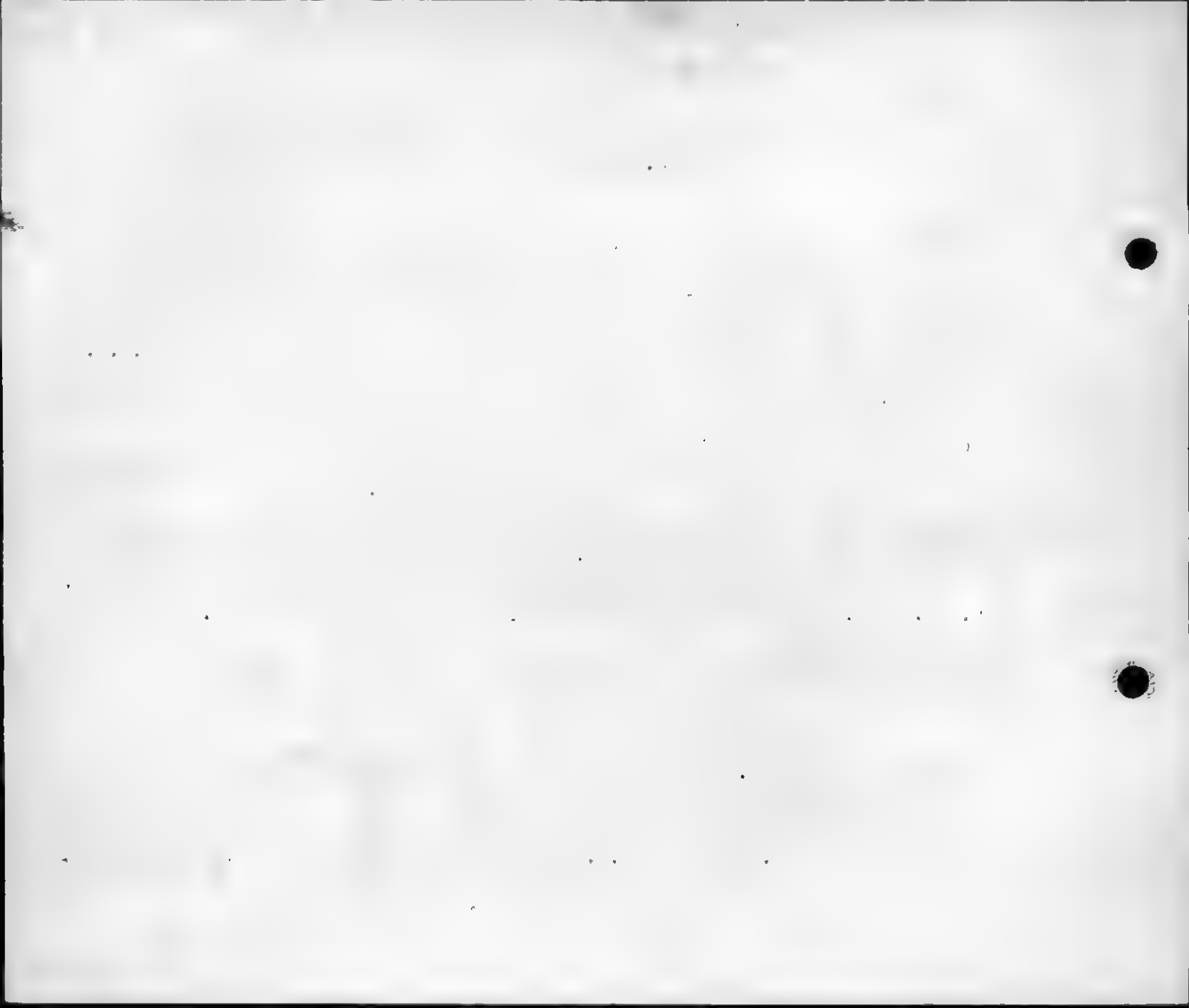
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page 3 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1809 CERTIFICATE OF DEATH

01798

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived - If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>			
c. LENGTH OF STAY IN 1b <u>1 mos. 19 days</u>				d. STREET ADDRESS <u>None</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Elihu Carlton</u>				4. DATE OF DEATH Month Day Year <u>February 4, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1881</u>	9. AGE (In years lost birthday) yrs <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Carlton</u>				14. MOTHER'S MAIDEN NAME <u>Camelia Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-03-2556</u>		17. INFORMANT <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH Years
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u>							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Coronary arteriosclerosis</u>							Years
DUE TO							
(c) <u>Old and recent myocardial infarct in left ventricle wall</u>							Months & years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>September 15, 1959</u> , to <u>February 4, 1960</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3, 1960</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ellis S. Margolin</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/4/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ellis S. Margolin, M.D.</u>				22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 6 - 60</u>		<u>Upper cross Roads method</u>		<u>Baldwin Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Kelly</u>				ADDRESS <u>Jarrettsville Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>C. R. S. & K. S.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

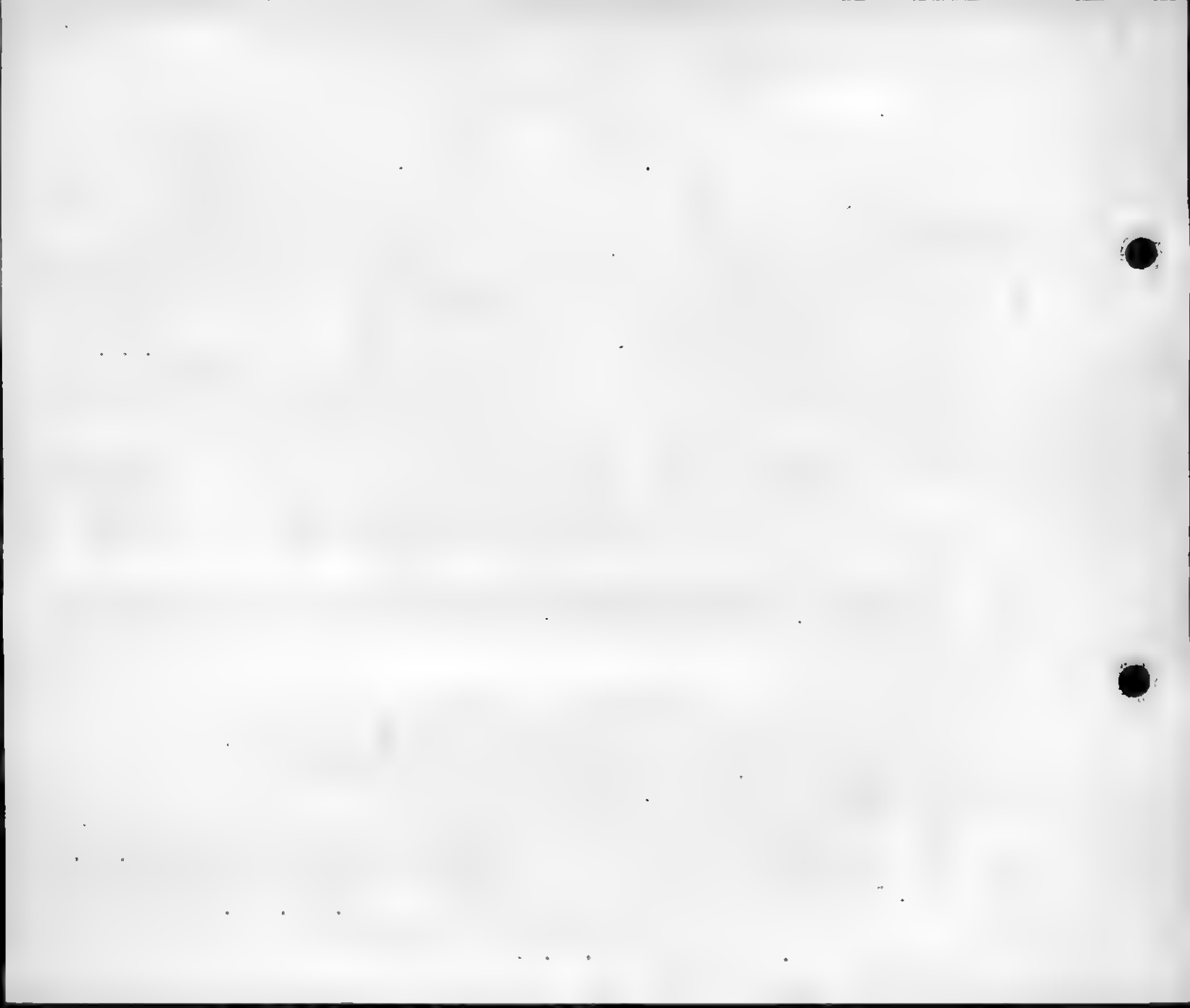
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01799

1810

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 7 mo. 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 403 Claybourne Avenue			
3 NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Cahill Casey				4 DATE OF DEATH Month February Day 1 Year 1960			
5 SEX Female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 21, 1863	9 AGE (In years last birthday) 96 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Cahill				14 MOTHER'S MAIDEN NAME Josephine Ryan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO None		17 INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH days years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 24, 1959 , to February 1, 1960 , that (I) (we) last saw the deceased alive on Jan. 31, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above							
22a SIGNATURE <i>Edmund Lusthaus</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 2/1/60	
22c PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				22d ADDRESS Springfield Hospital, Sykesville, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 2/4/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				ADDRESS Wash. D.C.		25a REC'D BY REGISTRAR DATE FEB 3 '60	
				25b. REGISTRAR'S SIGNATURE <i>Charles E. Hines</i>			



1811 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPYKESVILLE R.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>6 WEEKS</u>		d. STREET ADDRESS <u>58 E. MAIN ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GOLDEN AGE NURSING HOME - ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>C.</u> Last <u>COLWELL</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>WOODBINE, CARROLL CO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN P. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA E. BRICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS. CASPER J. BEHR</u>		Address <u>WESTMINSTER, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Arterio Sclerotic Cerebro-Vascular disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 15</u> 19 <u>60</u> to <u>Feb 7</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 6</u> 19 <u>60</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>2-8-60</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		ADDRESS (Street, city or town, state) <u>105 E. Main St. Westminster Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 9, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>RURAL, WESTMINSTER, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Meyers, Jr.</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '60</u>	
ADDRESS <u>Westminster, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law also requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

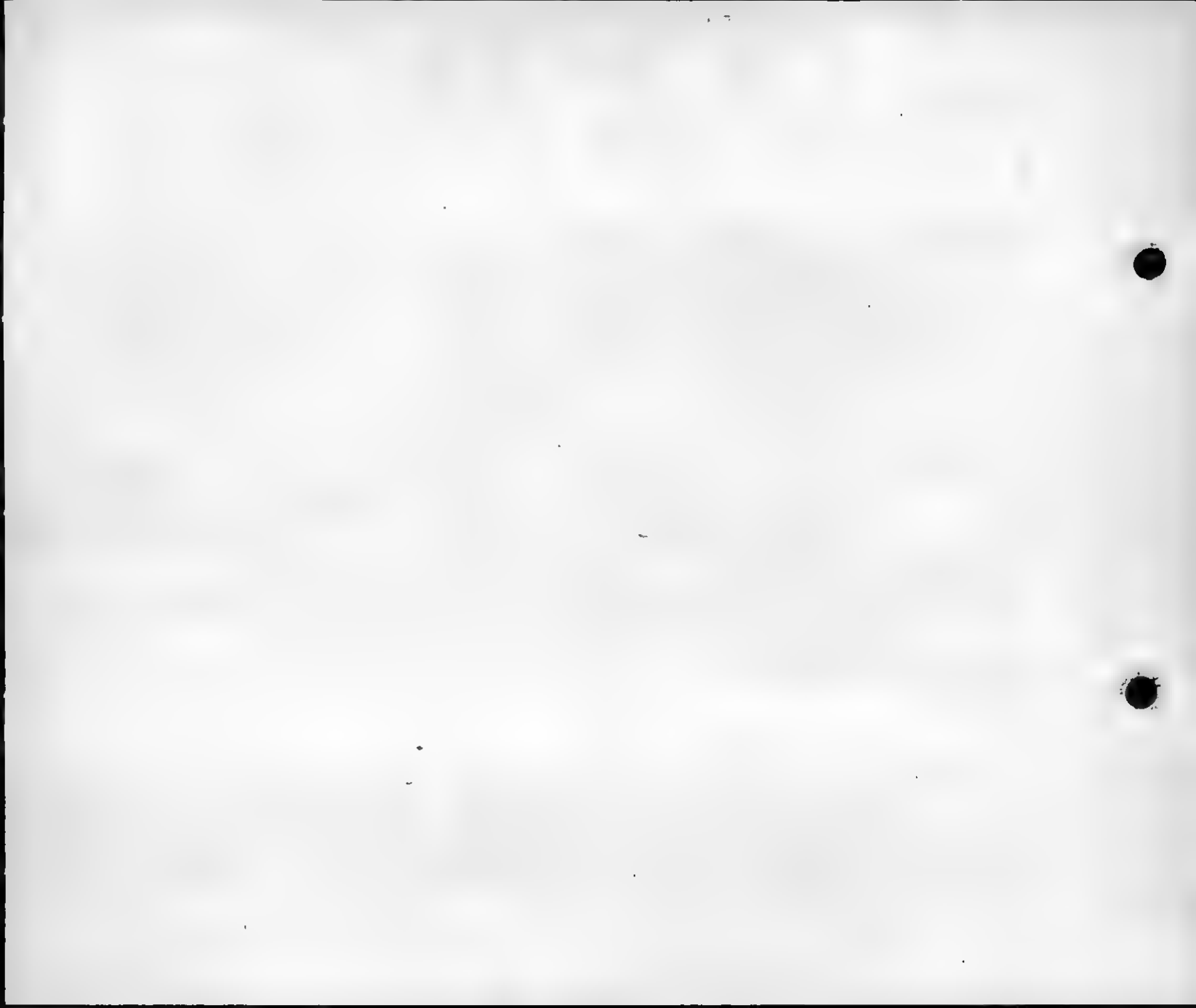
01801

Reg. Dist. No.

1798

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>N. CENTER ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOTTIE</u>		First		Middle <u>ISADORE</u>		Last <u>CRUMBACKER</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 23-1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN CAMPBELL</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL FLICKINGER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO <u>215-18-1243</u>		17. INFORMANT <u>HARRY K CRUMBACKER</u>		Address <u>WESTMINSTER MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> (c) <u></u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs + 8 mos</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>52</u> , to <u>Feb 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>60</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper ave. Westminister, Md.</u> DATE SIGNED <u>2/12/60</u>							
ACTUAL SIGNATURE <u>Dr. Reese Wilkens</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. Reese Wilkens Westminister, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Rocky Ridge, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler</u>		ADDRESS <u>Union Bridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneip</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 shall be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01892

1812

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seesville</u> c. LENGTH OF STAY IN lb <u>19 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Seesville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seesville</u> d. STREET ADDRESS <u>4 1/2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Douglas Cutts</u>			4. DATE OF DEATH Month Day Year <u>Febr. 6th 19 60</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1886</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rec. in Treas. Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>			
13. FATHER'S NAME <u>James M. Cutts</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Wheeler</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/> (If yes, give year or dates of service) <u>X</u>		16. SOCIAL SECURITY NO <u>X</u>		INFORMANT Address <u>Records of Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic alcoholism, Korsakow's</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>July 1st 1953</u> to <u>Febr 5th 1960</u> , that I last saw the deceased alive on <u>Febr 6th 1960</u> , and that death occurred at <u>8:55 a.m.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Spring State Hosp.</u> DATE SIGNED <u>2-6-60</u>							
ACTUAL SIGNATURE <u>Myron Mizankowsky</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Myron Mizankowsky</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wash, D.C.</u> <u>The S.H.Hines Co., 2901 14th St. N.W.</u>			24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01803

1. PLACE OF DEATH
a. COUNTY **Carroll** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Middleburg**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **Maryland** b. COUNTY **Carroll**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Middleburg**
d. STREET ADDRESS

3. NAME OF DECEASED
(Type or print) **Sherry Anne Dedmon**
First Middle Last

4. DATE OF DEATH **February 27 1960**
Month Day Year

5. SEX **female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Nov. 8, 1959**
9. AGE (In years last birthday) **1** yrs. **1** Months **1** Days IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Hannover Hopt. Hannover Pa., U.S.A.**
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Alfred D. Dedmon** 14. MOTHER'S MAIDEN NAME **Nancy Lou Scott**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO 17. INFORMANT **Alfred D. Dedmon, Middleburg Md.**
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Pneumonia**
493X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE **Charles S. Petty** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **Charles S. Petty** ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED **2/28/60**
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **March 1, 60** 22c. NAME OF CEMETERY OR CREMATORY **Lutheran Cemetery** 22d. LOCATION (City, town, or country) (State) **Uniontown Carroll Co. Md.**

23. FUNERAL DIRECTOR **J. E. Myers, Jr., Westminster, Md.** ADDRESS 24a. REC'D BY REGISTRAR **MAR 2 '60** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01804

1814 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) -79 STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u>	
c. LENGTH OF STAY IN 1b <u>3 weeks</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookfield Manor</u>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GEORGE - H - DIEHL</u> First Middle Last		4. DATE OF DEATH <u>February 23</u> Month Day Year 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 2-1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Helen Stoner</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 16</u> 19 <u>60</u> , to <u>FEB 23</u> 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 22</u> 19 <u>60</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas H. Legg</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Bridge, MD</u> DATE SIGNED <u>2-23-60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas H. Legg, M.D.</u>		<u>Union Bridge, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



1

1815

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

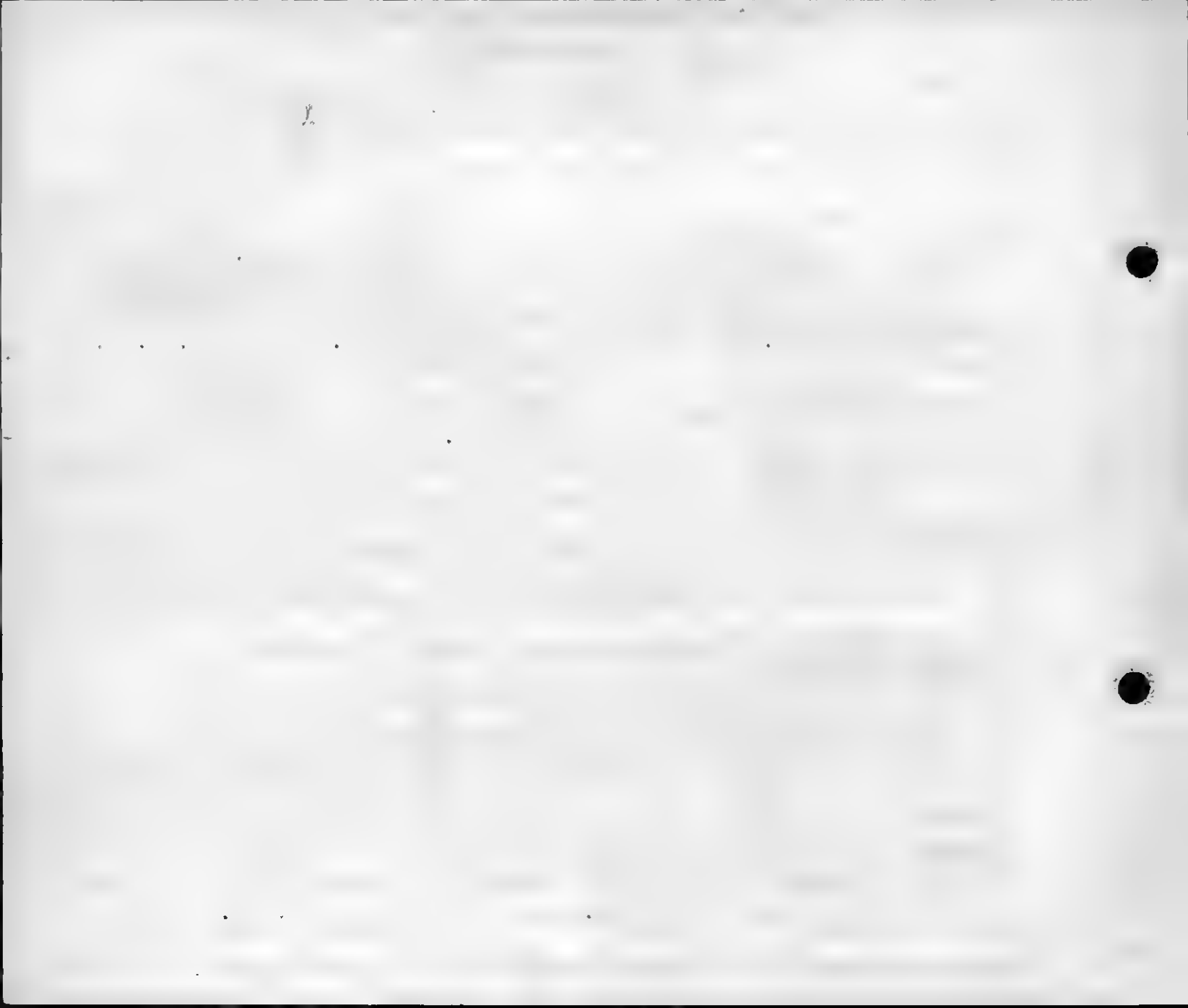
CERTIFICATE OF DEATH

01805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Datour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RD#8	
3. NAME OF DECEASED (Type or print) Martha Coulson Dohm		4. DATE OF DEATH Month Feb. Day 25 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1921
9. AGE (In years last birthday) 38 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Op.		10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.	
11. BIRTHPLACE (State or foreign country) Hanover, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Roy Coulson		14. MOTHER'S MAIDEN NAME Mary Bair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 183-18-7648	
17. INFORMANT George J. Dohm		18. ADDRESS Reynolds Mill Rd. York RD#8, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma - Colon - Original Site DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/60 , 19 60 , to 2/25/60 , 19 60 , that I last saw the deceased alive on 2/25/60 , 19 60 , and that death occurred at 7 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. E. Robertson		M.D. New Windsor, Md. DATE SIGNED 2/25/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2-28-1960	York Rd. Cemetery	Hanover, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Dennis R. G. Metzger		24a. REC'D BY REGISTRAR DATE MAR 1 '60	
ADDRESS 542 Carlisle St. Hanover, Pa.		24b. REGISTRAR'S SIGNATURE Charles S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01806

1816 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. LENGTH OF STAY IN 1b <i>3 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FANNIE ARDEEN DUVALL</i>		4. DATE OF DEATH <i>Feb. 16 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27, 1875</i>
9. AGE (In years, last birthday) <i>84 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Mosley</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Baker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Alfred White - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		<i>Sudden</i>	
DUE TO (b) <i>Hypertension</i>		<i>Years</i>	
DUE TO (c) <i>Generalized Arteriosclerosis</i>		<i>Years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chr. Heart failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 27, 1957</i> , to <i>Feb. 16, 1960</i> , that (I) (we) last saw the deceased alive on <i>Jan 16, 1960</i> , and that death occurred <i>PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Sani Okutman</i> M.D.		22b. DATE SIGNED <i>Feb. 17, 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>		22d. ADDRESS <i>Sykesville, Md.</i>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-19-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Montgomery Chapel</i>	23d. LOCATION (City, town, or county) (State) <i>Mt. Damascus, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		25a. REC'D BY REGISTRAR <i>Feb 23 '60</i>	
ADDRESS <i>Sykesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur H. Haight</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

179S

CERTIFICATE OF DEATH

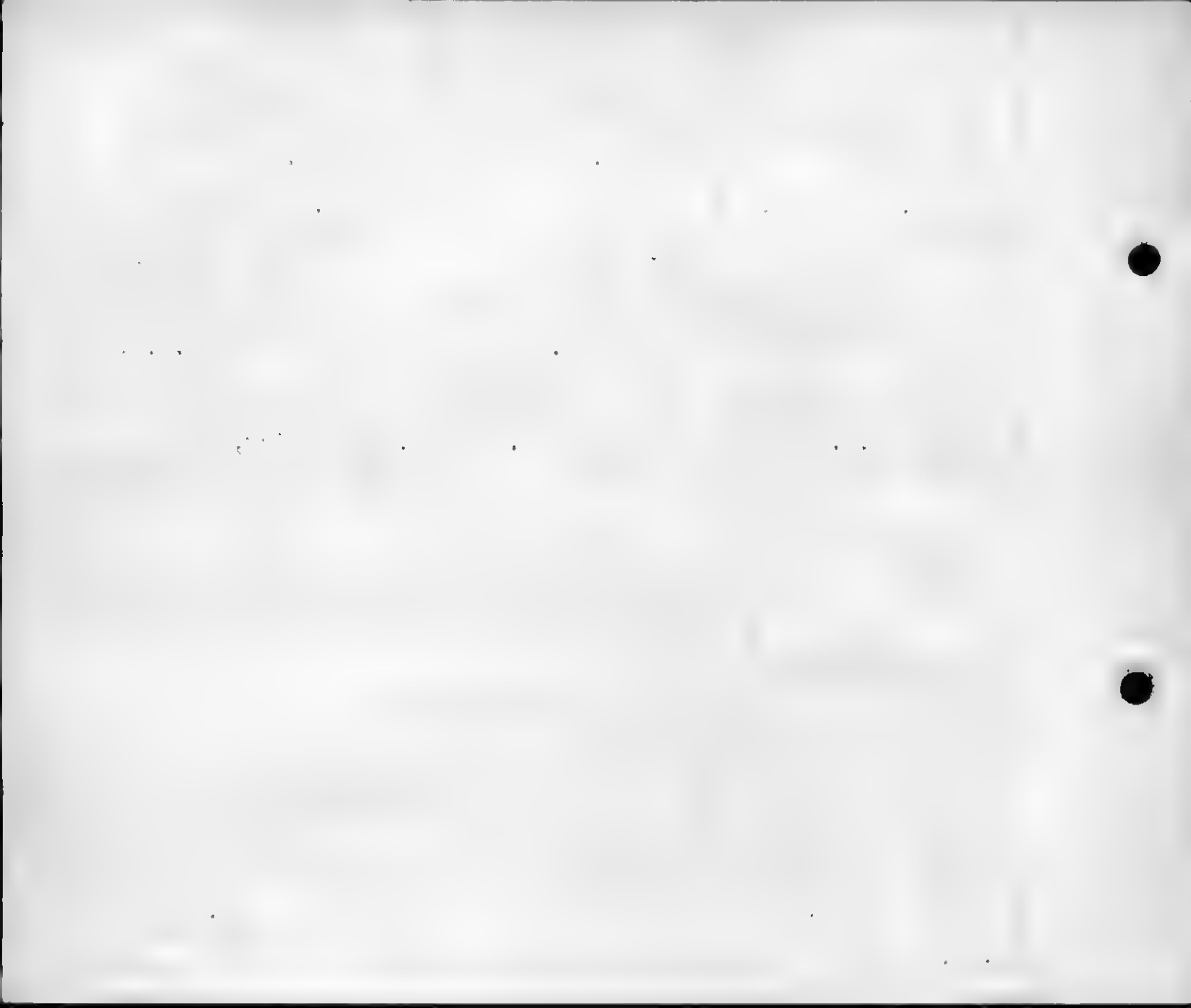
01807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 169 W. Main, St.		d. STREET ADDRESS 169 W. Main, St.	
3. NAME OF DECEASED (Type or print) CLIFFORD V. ESWORTHY		4. DATE OF DEATH Month February Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1914
9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman		10b. KIND OF BUSINESS OR INDUSTRY Carroll Dist.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Howard Esworthy		14. MOTHER'S MAIDEN NAME Margaret Helen Black	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 215-26-1503	
17. INFORMANT Mrs. Ella M. Mc Cormick,		Address Same	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 6 mos +
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-17- 19 59 , to Feb 1 19 60 ; that I last saw the deceased alive on Jan 15 19 60 , and that death occurred at 8 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James J. Shorok M.D.		ADDRESS (Street, city or town, state) 105 E Shorok St DATE SIGNED 2/1/60	
PHYSICIAN'S NAME (Type) JAMES T. MARSH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 4, 1960	22c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1817 CERTIFICATE OF DEATH

01808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 1,057 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. STREET ADDRESS 3447 Chessel Court	
3. NAME OF DECEASED (Type or print) First Arthur Middle Lee Last Faison		4. DATE OF DEATH Month February Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-24
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Farmville, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Faison		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 227-26-0680	
INFORMANT Arthur Faison - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor-Pulmonale DUE TO (c) Far advanced bilateral pulmonary tbc.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 20, 1957 , to February 10, 1960 , that I last saw the deceased alive on February 10, 1960 , and that death occurred at 4:50A M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Elgars M. Maculans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 2-10-60			
PHYSICIAN'S NAME (Type) Dr. E. M. Maculans, Supt.		Henryton State Hospital Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 13, 1960	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	22d. LOCATION (City, town, or county) (State) Neotoma (Baltimore) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph S. Russ		24a. REC'D BY REGISTRAR FEB 15 '60	
ADDRESS 2922 W. North Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1818 CERTIFICATE OF DEATH

01809

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jeffersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jeffersville</u>			
c. LENGTH OF STAY IN 1b <u>10 years</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wilson Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>ARMITA</u> Middle <u>FITZ</u> Last <u>E</u>				4. DATE OF DEATH <u>Feb. 3</u> 19 <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Scott Waddell</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Herman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Mrs. James Ribbett - Jeffersville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, arteriosclerotic heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decom. arteriosclerotic generalized, Arteriosclerosis</u> DUE TO (c) <u>Bronchial pneumonia.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1954 to 3 Jan 60</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> 19 <u>54</u> to <u>3 Jan</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>3 Jan</u> 19 <u>60</u> and that death occurred at <u>7:38 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u> M.D.				22b. DATE SIGNED <u>2/4/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				22d. ADDRESS <u>Jeffersville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-6-60</u>		<u>Meadow Branch</u>		<u>Jeffersville, Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Haight</u> ADDRESS <u>Jeffersville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haight</u>			



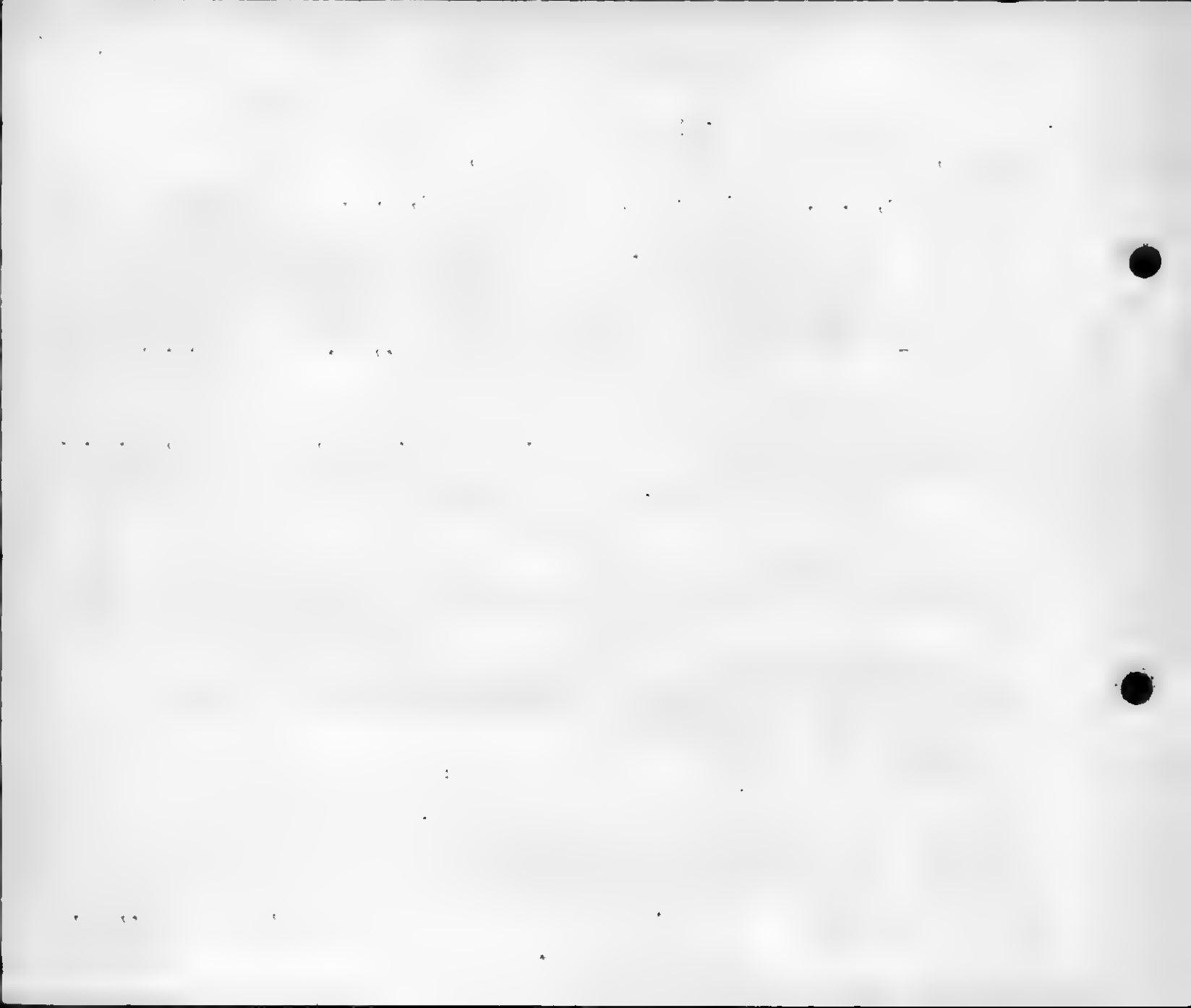
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1819 CERTIFICATE OF DEATH

Reg. Dist. No.

01810

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) Westminster, R. D. 1 (Silver Run)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emma J. Fitze		4. DATE OF DEATH Month Day Year February 23 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1881
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework		10b. KIND OF BUSINESS OR INDUSTRY In her own home	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Yingling		14. MOTHER'S MAIDEN NAME Almeda Burgoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles A. Leppo, Westminster, Md. R.D.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Endometrial Carcinoma of Uterus 174x DUE TO with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 13, 1957 to February 23, 1960 , that I last saw the deceased alive on February 20, 1960 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 W. KING ST. LITTLESTOWN, PA DATE SIGNED ACTUAL SIGNATURE L. P. Potter M.D. L. L. POTTER M.D. 12 W. KING ST. LITTLESTOWN, PA PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/26/60	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		24a. REC'D BY REGISTRAR DATE FEB 25 '60	
ADDRESS Littlestown, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

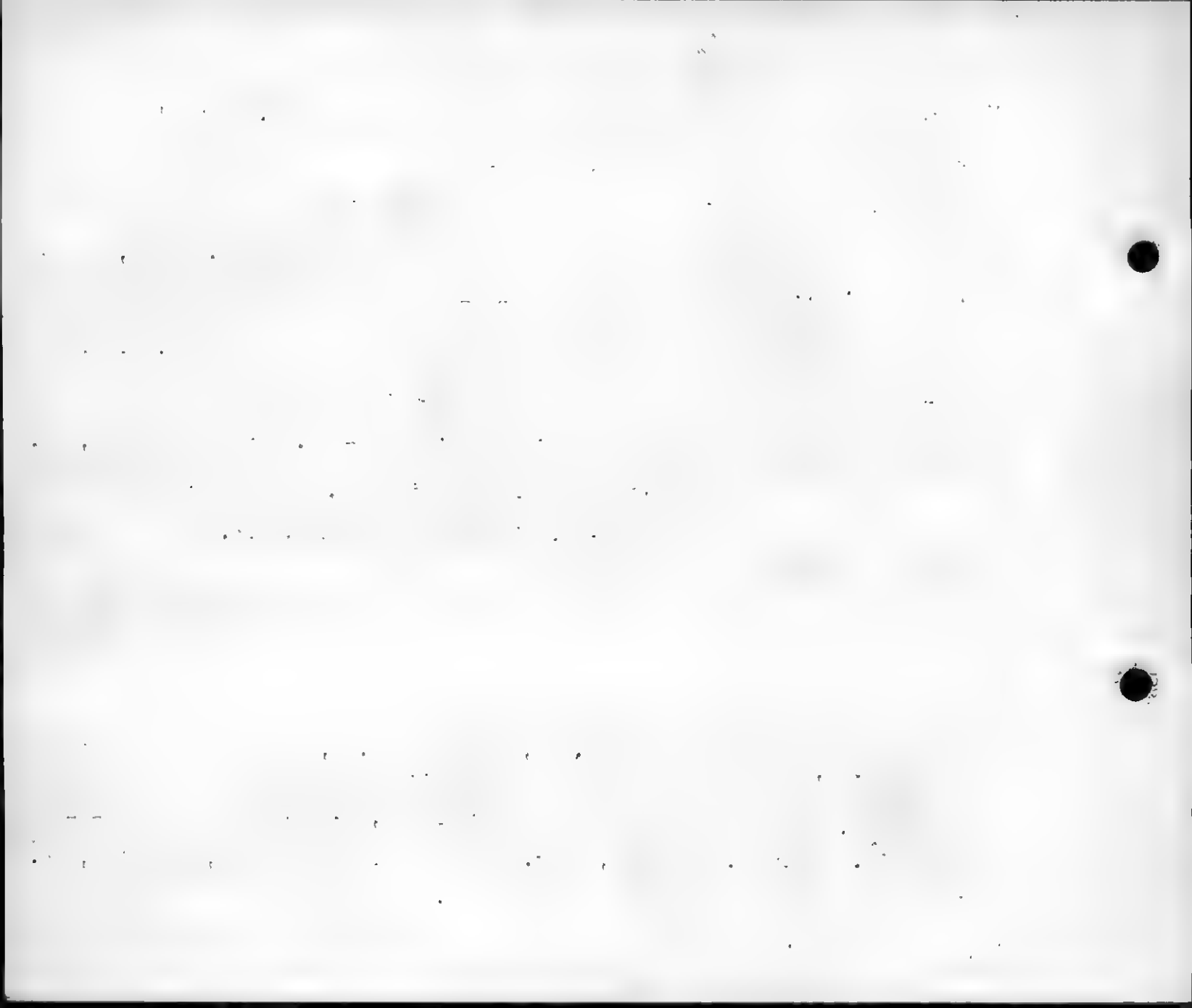
Reg. Dist. No.

1820

01811

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN lb 618 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville 1674.2 d. STREET ADDRESS 5516 Odell Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Gaither		4. DATE OF DEATH Month Day Year Feb. 5, 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Record - Pr. George's County, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency, Assian Flu 002X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Far advanced bilateral pulmonary Tbc. DUE TO (c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 17, 1958 to Feb. 5, 1960 , that I last saw the deceased alive on Feb. 5, 1960 , and that death occurred at 6:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edgars M. Maculans		ADDRESS (Street, city or town, state) Henryton, Maryland	
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.		DATE SIGNED 2-5-60	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
2-10-60	2-10-60	Queens Chapel Cem	Muirkirk Md
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Schuchman		ADDRESS 4925 Annapolis	
24a. REC'D BY REGISTRAR DATE FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

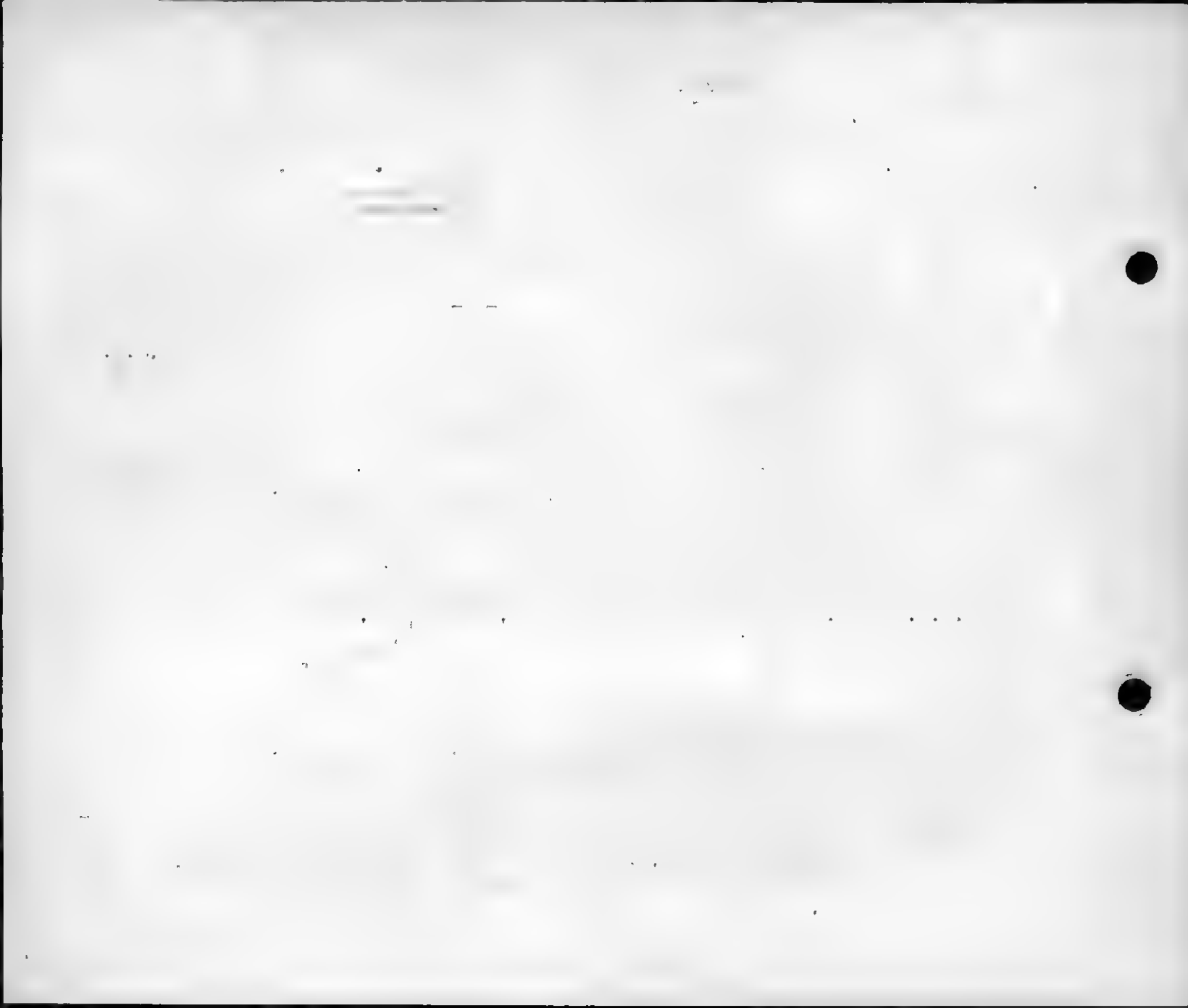


1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1821
CERTIFICATE OF DEATH

01812

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>2 n 8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Baltimore 23, Md.</u> <u>1129 Gardner Street</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Gardiner</u> Last <u>Gardiner</u>				4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-88</u>	9. AGE (In years lost birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Gardiner</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Lyons</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>unkn</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pulmonary Tuberculosis, far advanced</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arterioscler. with psych. reaction, late latent syphilis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-27-</u> <u>19 59</u> to <u>2-5-</u> <u>19 60</u> that (I) (we) last saw the deceased alive on <u>2-5-</u> <u>19 60</u> , and that death occurred at <u>8: PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edmund Lusthaus</u>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>				22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Asid. J. Cole</u>				ADDRESS <u>1913 W. Baltimore St</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>C. J. S. Kenna</u>				25c. REGISTRAR'S NAME <u> </u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

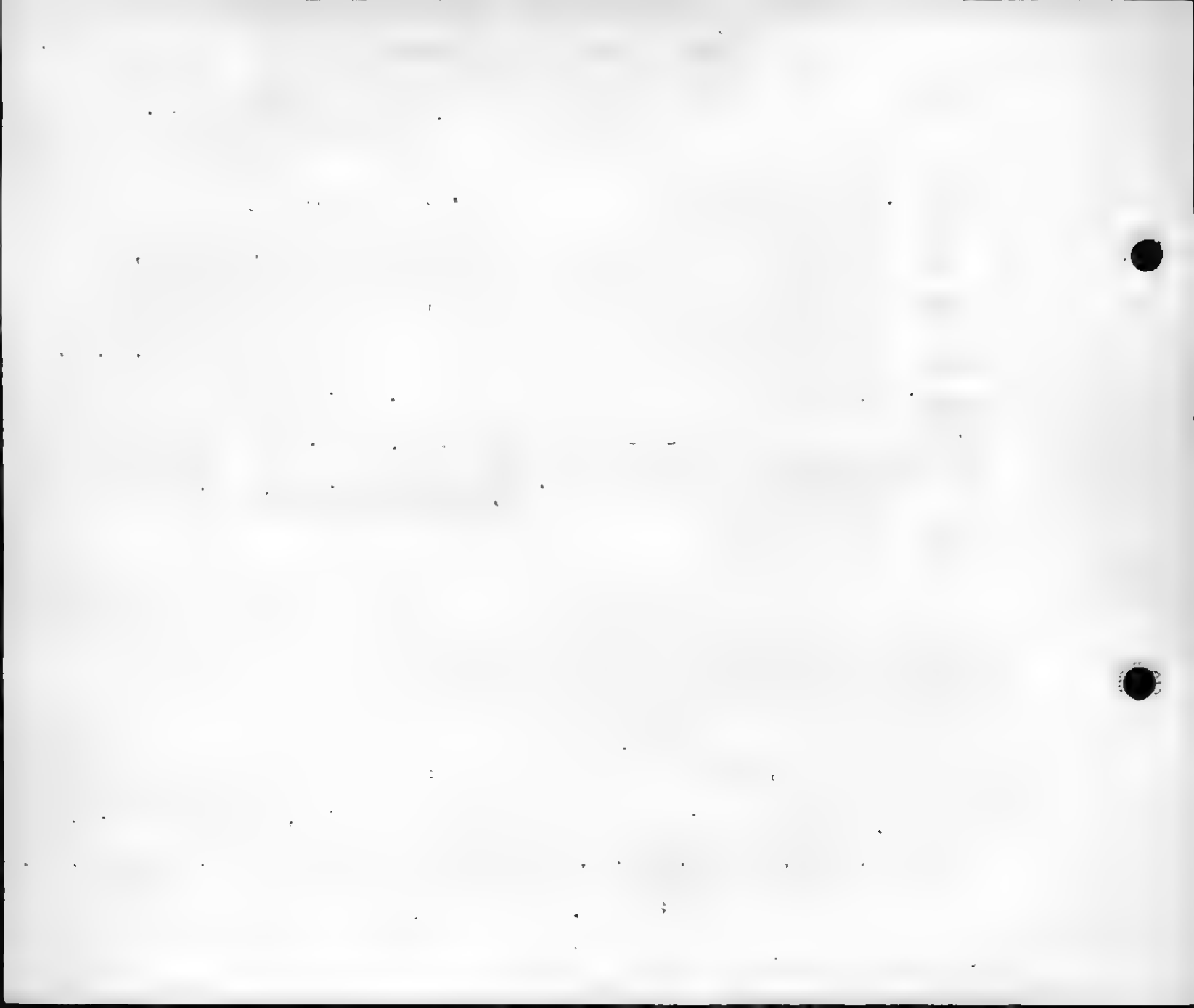
1822 CERTIFICATE OF DEATH

Reg. Dist. No.

01813

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 973 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Calvin Middle Wilmer Last Gardner				4. DATE OF DEATH Month February Day 10 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 10, 1915		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Whitehall, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George W. Gardner				14. MOTHER'S MAIDEN NAME Annie M. Givens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-4223		INFORMANT Address Calvin W. Gardner - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Bilateral Pulmonary Tuberculosis with Cavitation right DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1957 , to February 10, 1960 , that I last saw the deceased alive on February 10, 1960 , and that death occurred at 7:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgers M. Maculans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 2-10-60			
PHYSICIAN'S NAME (Type) Dr. E. M. Maculans, Supt.		Henryton State Hospital, Henryton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-17-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY W & M Mattingly Bury		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell		ADDRESS Pikes &		24a. REC'D BY REGISTRAR FEB 18 '60		24b. REGISTRAR'S SIGNATURE Wm. S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

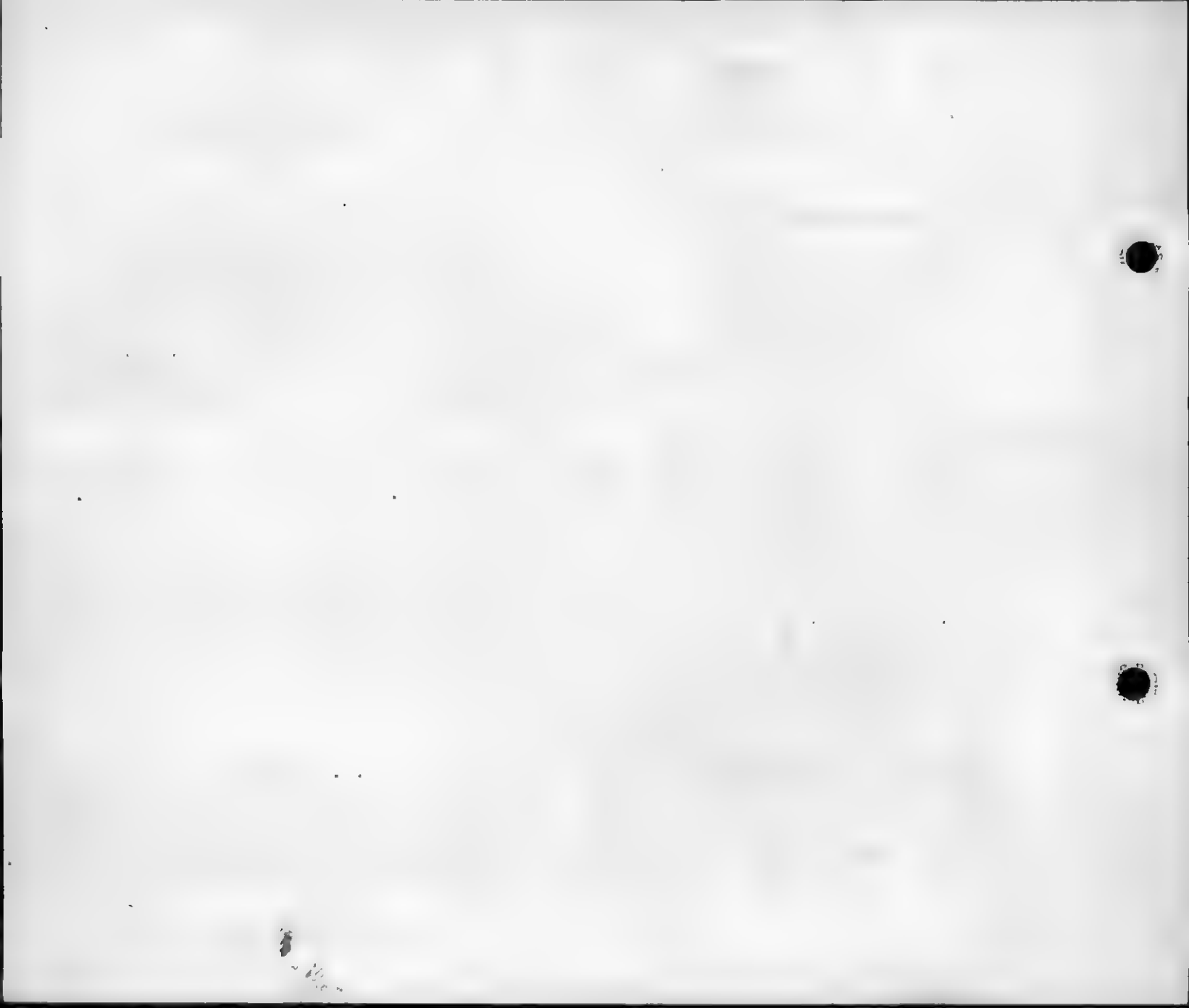


may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1823
CERTIFICATE OF DEATH

01814

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 2yr.10mo.21days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 610 Oldham Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Luigi - Giordano				4. DATE OF DEATH Month Day Year February 23 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 12, 1883	
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolar nephrosclerosis. 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction Late latent syphilis						INTERVAL BETWEEN ONSET AND DEATH Years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 1					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1 19 58 to February 23 19 60 that (I) (we) last saw the deceased alive on February 23 19 60 and that death occurred at 9:20 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo				22b. DATE SIGNED 2/23/60		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-60		23c. NAME OF CEMETERY OR CREMATORY New Catholic		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Hught ADDRESS Springfield, Md.				25a. REC'D BY REGISTRAR DATE FEB 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hana	



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1825 CERTIFICATE OF DEATH

01816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Union Bridge</u>		c. LENGTH OF STAY IN 1b <u>16 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		d. STREET ADDRESS <u>Rural - Union Bridge</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA M. HAMILTON</u>		4. DATE OF DEATH Month Day Year <u>Feb. 24 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jamison</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Jamison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. H.G. Staley, Union Bridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Pulmonary Hypertension</u> DUE TO <u>4 yrs</u> (c) <u>Pulmonary Emphysema</u> <u>4 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>4 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis, Cholelithiasis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 6, 1956</u> to <u>Feb 24 1960</u> that I last saw the deceased alive on <u>Feb 15 1960</u> and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Taney Town Md</u> DATE SIGNED <u>2/25/60</u>			
ACTUAL SIGNATURE <u>E. Ambler Thompson</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton</u> ADDRESS <u>Weskersville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 29 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Catharine L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

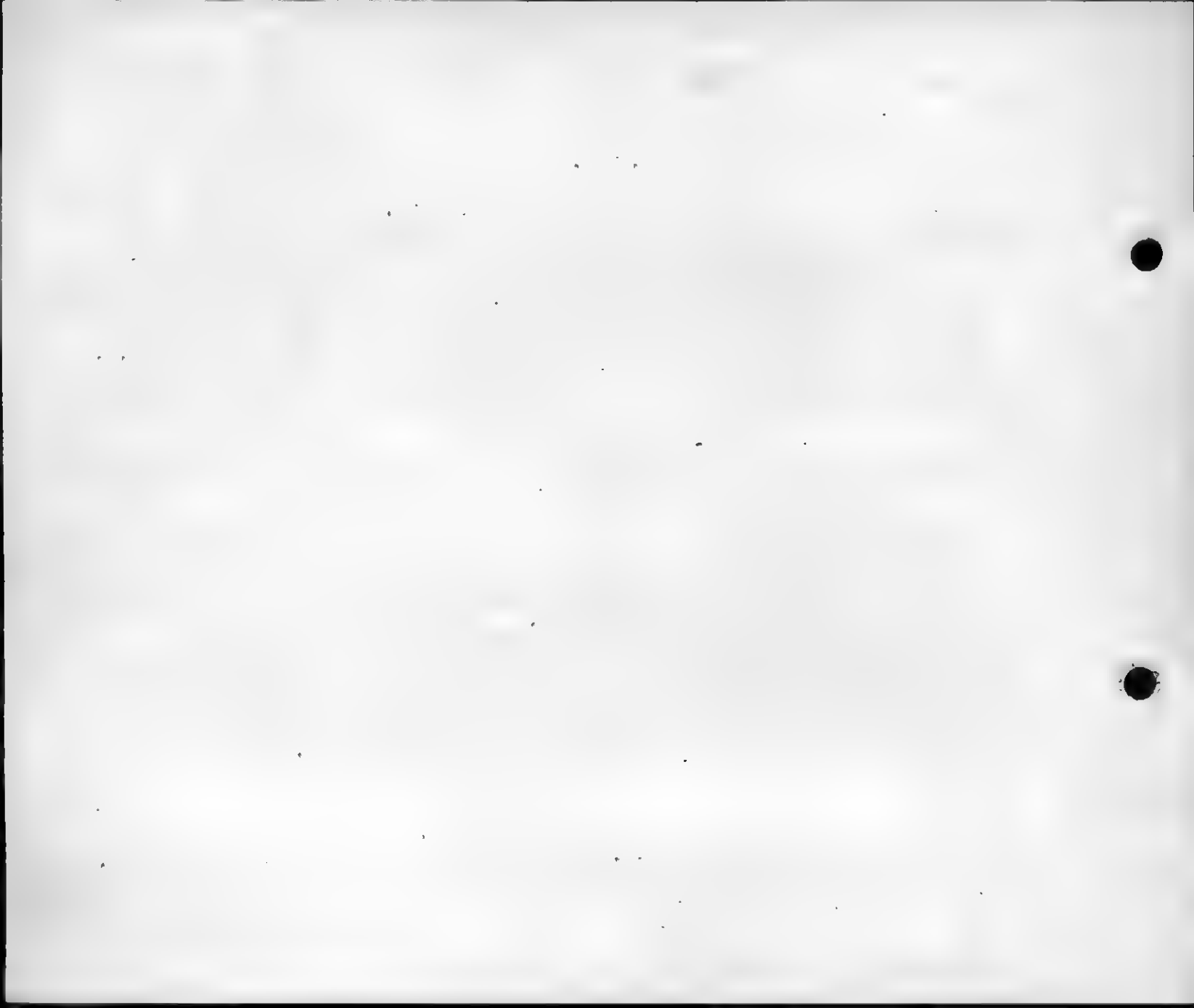


1

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01817

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>1826</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spikesville</u>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
c. LENGTH OF STAY IN 1b <u>10yrs. 4mos. 25days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spikesville State Hospital</u>		d. STREET ADDRESS <u>- Park Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u>Charles</u> Last <u>Hammond</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Selling chickens</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Alice -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emile psychosis, simple deterioration.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1955</u> to <u>Feb. 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>February 8 1960</u> , and that death occurred at <u>10:00 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Agustin del Campo</u> M.D.		22b. DATE SIGNED <u>2/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Spikesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/15/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Knight</u>		25a. REC'D BY REGISTRAR <u>FEB 17 1960</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur A. Knight</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

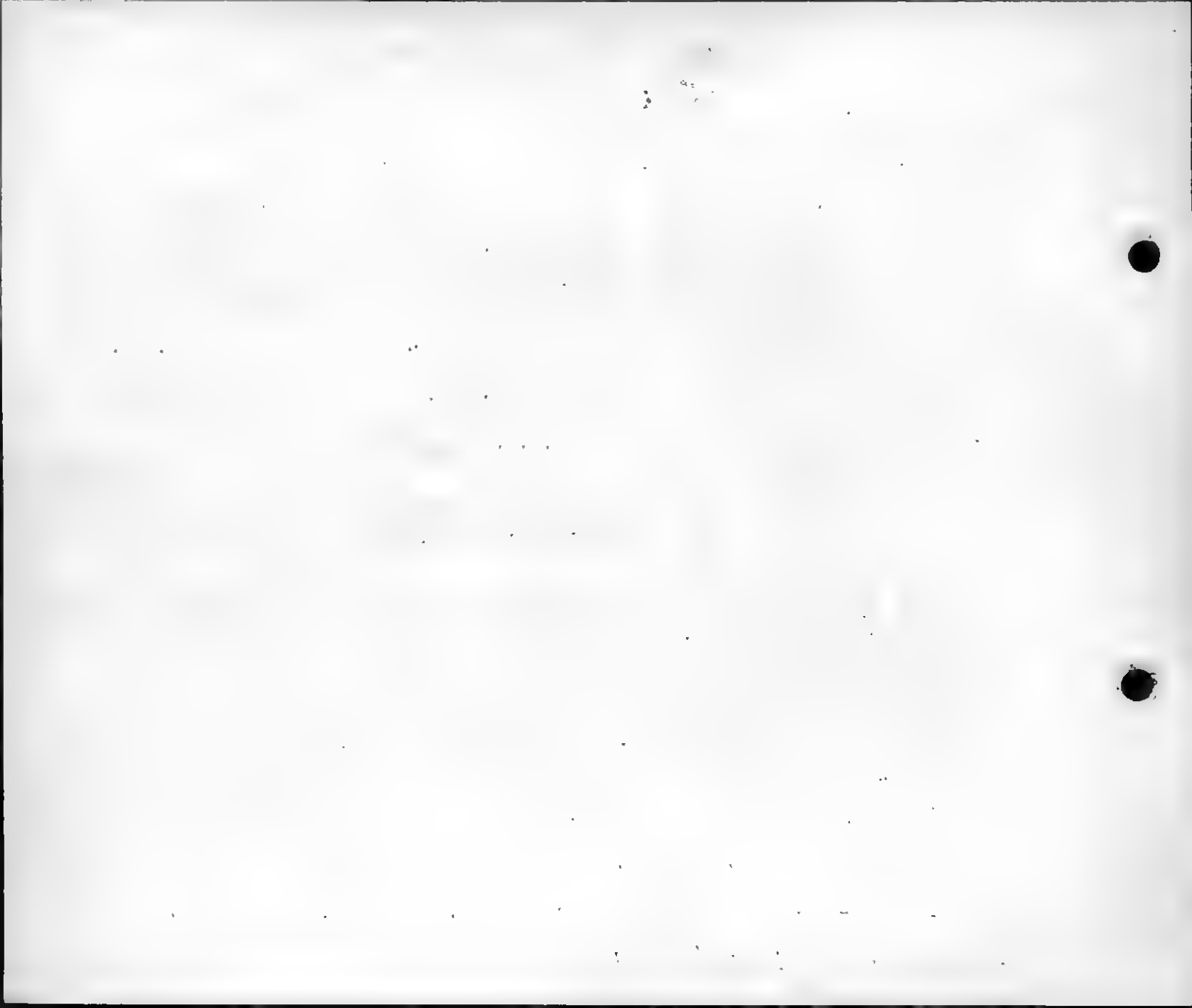
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1827 CERTIFICATE OF DEATH

Reg. Dist. No.

01818

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 2, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>8mos. 18days</u>		d. STREET ADDRESS <u>1822 North Charles Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ethel</u> Last <u>HANSON</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>10</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hanson</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>S.S.H. Records</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24</u> hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>59</u> , to <u>February 8</u> , 19 <u>60</u> that I last saw the deceased alive on <u>February 7</u> , 19 <u>60</u> , and that death occurred at <u>3:20AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Agustin del Campo</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>2-8-60</u>	
PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M. D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. H.</u>	



1828

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hampstead</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN - T - HARRIS</u> First Middle Last		4. DATE OF DEATH <u>Feb 2</u> Month Day Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26 - 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Blizzard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>42-18-4306</u>	
17. INFORMANT <u>Catherine L. Wolfe - Hampstead Md</u>		Address <u>Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>Old Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>8 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>February 2, 1960</u> , and that death occurred at <u>3p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>2/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2-6-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eduw E Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>FEB 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1829

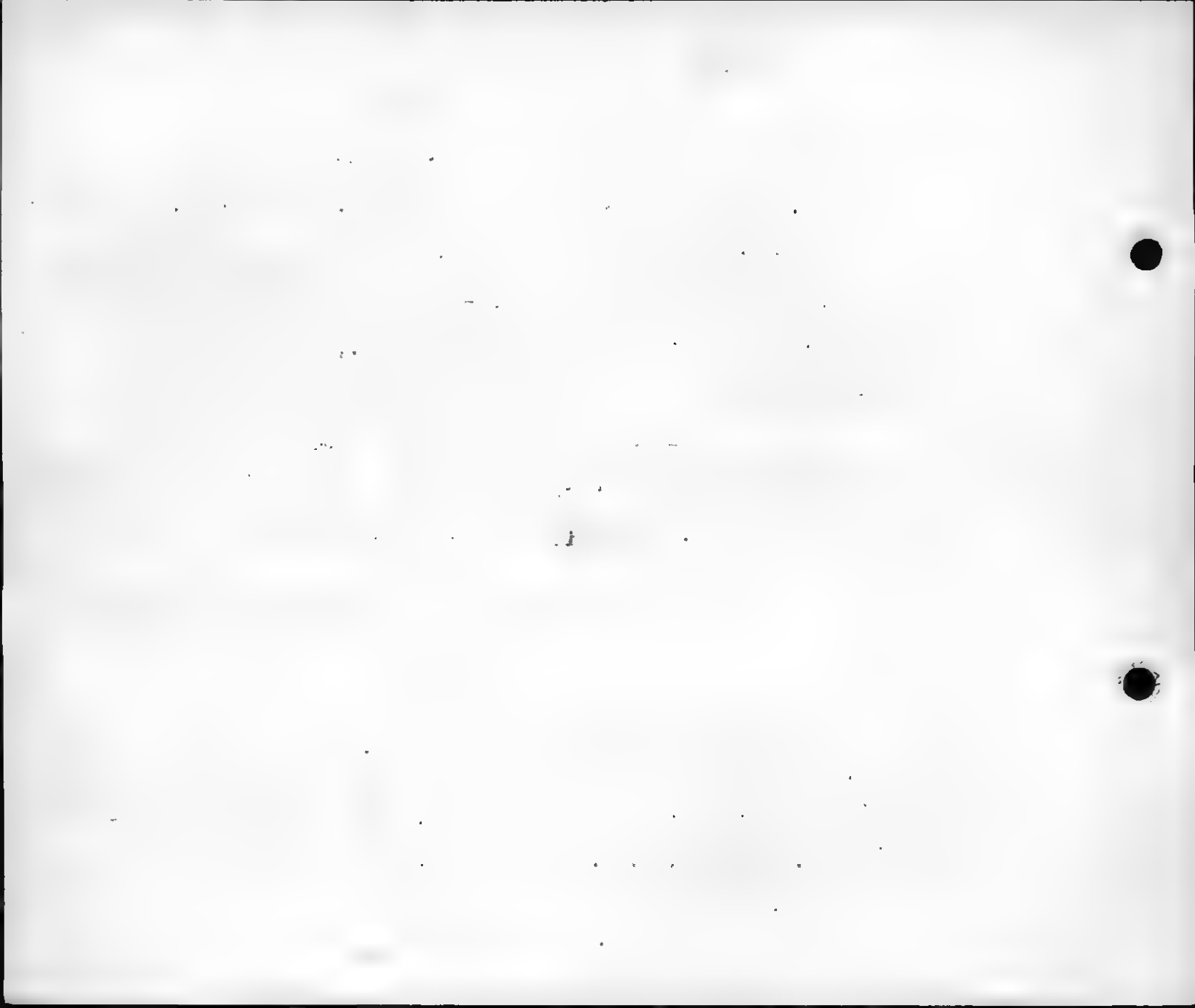
CERTIFICATE OF DEATH

Reg. Dist. No. **74**

01820

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				2. USUAL RESIDENCE (Where deceased lived, If institut an. Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2108 N. Rosedale St. • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Douglas Hawkins First Middle Last S SEX Male 6 COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 5-16-1887 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days Hours Min.			4. DATE OF DEATH February 19 19 60 Month Day Year				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Labour 10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Charles Co., Maryland 12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Dennis Hawkins		14. MOTHER'S MAIDEN NAME Nettie ??					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-3172					
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency (b) Virus pneumonia and tuberculosis left (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from February 15 19 60 , to Feb. 19 19 60 , that I last saw the deceased alive on Feb. 19 19 60 , and that death occurred at 12 Noon , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgars M. Maculans M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 2-19-60			
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		Henryton State Hospital					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.			
22d. LOCATION (City, town, or county) Ch. Co. Md.		(State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE John M. Johnson		ADDRESS 1700 E. 1st St. Baltimore		24a. REC'D BY REGISTRAR Feb 23 '60			
24b. REGISTRAR'S SIGNATURE William S. Thomas		_____					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

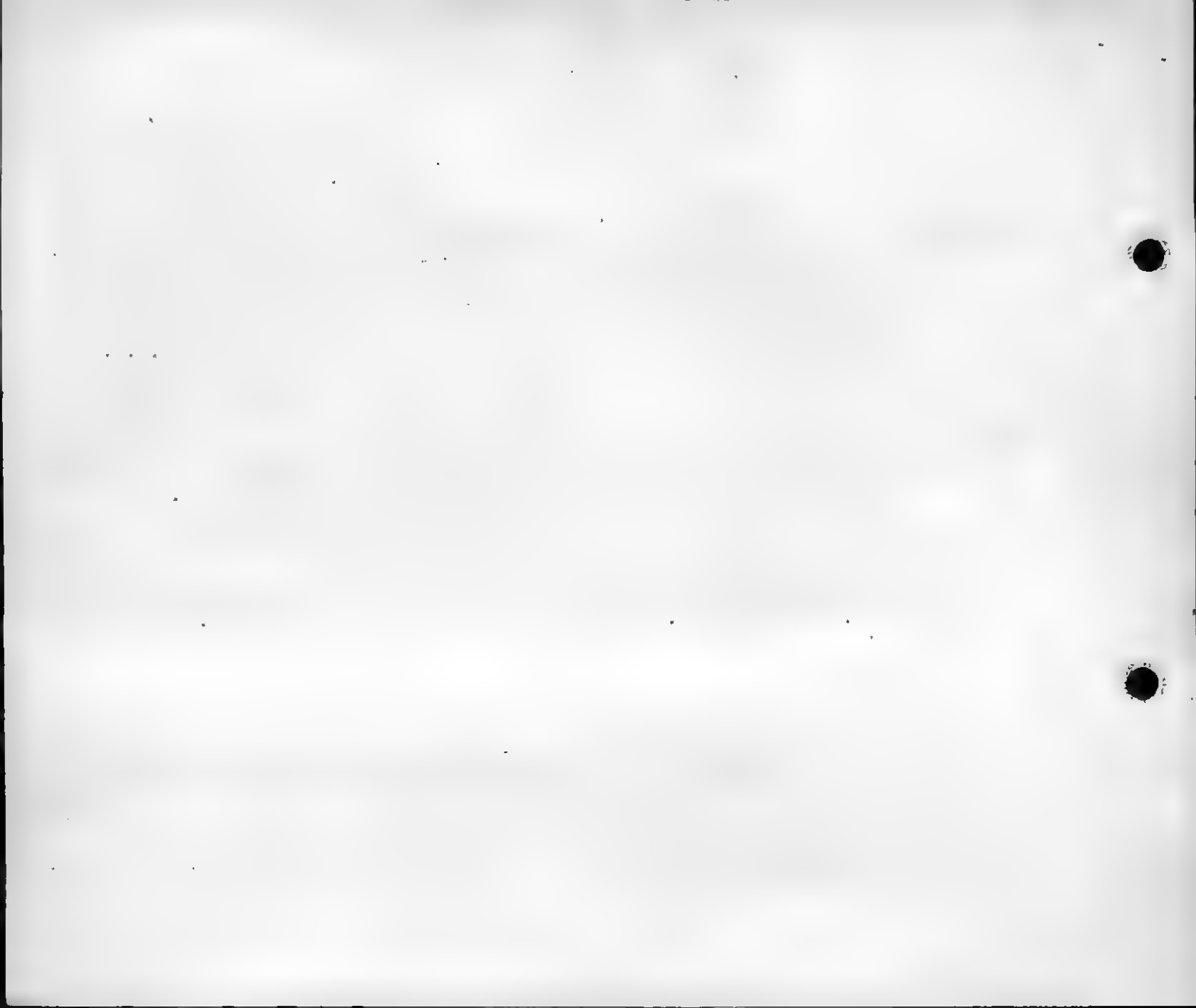


1830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01821

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 1yr 5 m 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md/	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 4507 XXXXXX Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle Josephine Last Himmighoef		4. DATE OF DEATH Month 2 Day 6 Year 19 60	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-1881
9. AGE (In years and birth day) 79 yrs.		10. IF UNDER 1 YEAR 10 Months 13 Days	11. IF UNDER 24 HRS. 13 Hours 13 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philipp Jacobs		14. MOTHER'S MAIDEN NAME Sophie Kettlekamp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease, inactive, with mitral sten. DUE TO (b) 10X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) 10X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.R.S. assoc. with circulat. disturbance with cerebral arteriosclerosis with psych. reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-26-58 , 19 58 , to 2-6- , 19 60 that (I) (we) last saw the deceased alive on 2-6- , 19 60 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Edmund Lusthaus M.D.		22b. DATE SIGNED 2-7-60	
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-10-60	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	23d. LOCATION (City, town, or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR FEB 9 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



1831

CERTIFICATE OF DEATH

01822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md RD #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md RD #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Mills</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WILLIAM HOOK</u>		4. DATE OF DEATH Month Day Year <u>FEB. 10 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>formal painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George William Hook</u>		14. MOTHER'S MAIDEN NAME <u>Catherine ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Walter H. Hook, Westminster RD #1 Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis, w/ myocardial degeneration</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Bronchitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-9</u> , 19 <u>57</u> , to <u>2-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>60</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. R. Potter M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>12 W. KING ST. LITTLESTOWN, PA 2-10-60</u>	
PHYSICIAN'S NAME (Type) <u>L. L. POTTER M.D.</u>		<u>12 W. KING ST. LITTLESTOWN, PA</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Union Mills, Westminster Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. E. Myers Jr. Westminster, Md</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		RD#	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1832

1832

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01823

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1yr. 4mo. 20days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 825 N. Mount Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah First Middle Last - Hare Isaacson			4. DATE OF DEATH Month Day Year February 19 1960				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1864	9. AGE (In years lost birthday) 95 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. JSUAL. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Russia			
13. FATHER'S NAME Samuel Hare			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 7 1955 to February 19 1960 , that (I) (we) last saw the deceased alive on February 19 1960 and that death occurred at 3:40 p.m. from the causes and on the date stated above							
22a. SIGNATURE Agustin del Campo		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/19/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-21-1960		23c. NAME OF CEMETERY OR CREMATORY HERRING RUN			
23d. LOCATION (City, town, or county) BALTO. MD		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc - 2103 EUTAW PLACE		ADDRESS 2103 EUTAW PLACE		25a. REC'D BY REGISTRAR FEB 23 '60			
				25b. REGISTRAR'S SIGNATURE Arthur S. Hume			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll 1800 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 328 E. MAIN Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster d. STREET ADDRESS 328 E. MAIN Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MILDRED Middle RAYBINE Last JACOBS			4. DATE OF DEATH Month February Day 26 Year 19 60								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH June 21, 1897		9. AGE (In years last birthday) 62 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland							
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Levi T. Truettell									
14. MOTHER'S MAIDEN NAME Anna Barber		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>									
16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Alice L. Brown 503 E. Main St. Westminster, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Alcoholism. INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 							
20f. (City or town) 		(County) 		(State) 							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.											
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/27/60							
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		 									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery							
22d. LOCATION (City, town, or county) Westminster, Md.		(State) 									
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Meyer, Jr. Westminster, Md.		24a. REC'D BY REGISTRAR DATE MAR 3 1960		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please advise the medical director. Give Pages 1, 2, and 3 to the medical director. Page 4 should be retained by the medical examiner. Forward to the Chief Medical Examiner's Office along with form 1843. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1833 CERTIFICATE OF DEATH

Reg. Dist. No.

01825

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Bath</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockdale</i>	
c. LENGTH OF STAY IN 1b <i>1 1/2 yrs.</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wentzel Nursing Home</i>	
e. STREET ADDRESS <i>8401 Charnel Drive</i>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ELIZABETH</i> Middle <i>J</i> Last <i>JEAN</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>18</i> Year <i>1960</i>	
5 SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 7, 1873</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Bath Co., Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Walter H. Odel</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Doubleday</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-05-8407B</i>	
17. INFORMANT <i>Harold Power</i> Address <i>34 Chesapeake Ave</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma Pectum, pelvic metastases, 154X</i> DUE TO (b) <i>anemia, renal degeneration, cardiac</i> DUE TO (c) <i>failure - bronchial pneumonia</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>1951 to 18 Feb 60</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1959</i> , 19 <i>18 Feb</i> , to <i>18 Feb</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>18 Feb</i> , 19 <i>60</i> , and that death occurred at <i>11:45 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Applle, Ind</i> DATE SIGNED <i>18 Feb 60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/20/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>		22d. LOCATION (City, town, or county) (State) <i>Randallstown, Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jerry Byers</i> ADDRESS <i>8728 Liberty Road</i>		24a. REC'D BY REGISTRAR <i>FEB 24 '60</i> DATE	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hana</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01826

1834

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>5 mths 3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 23, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Freda</u> Middle <u>Susanna</u> Last <u>Kaiser</u>				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1960</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-06</u>	9 AGE (In years last birthday) <u>53</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wolf</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Grossman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>216-09-4168</u>		17. INFORMANT <u>S.S. Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Presenile Sclerosis (Alzheimer Disease)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with Alzheimer disease, Pulmonary Tuberculosis, minimal, with psychotic reaction, Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-24-</u> <u>1960</u> to <u>2-27-</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>2-27-</u> <u>1960</u> , and that death occurred at <u>2:15 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edmund Lusthaus</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <u>2-27-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>				22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/2/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore City</u> <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lester L. Lamm</u>				ADDRESS <u>17401 Belair Rd</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.)



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

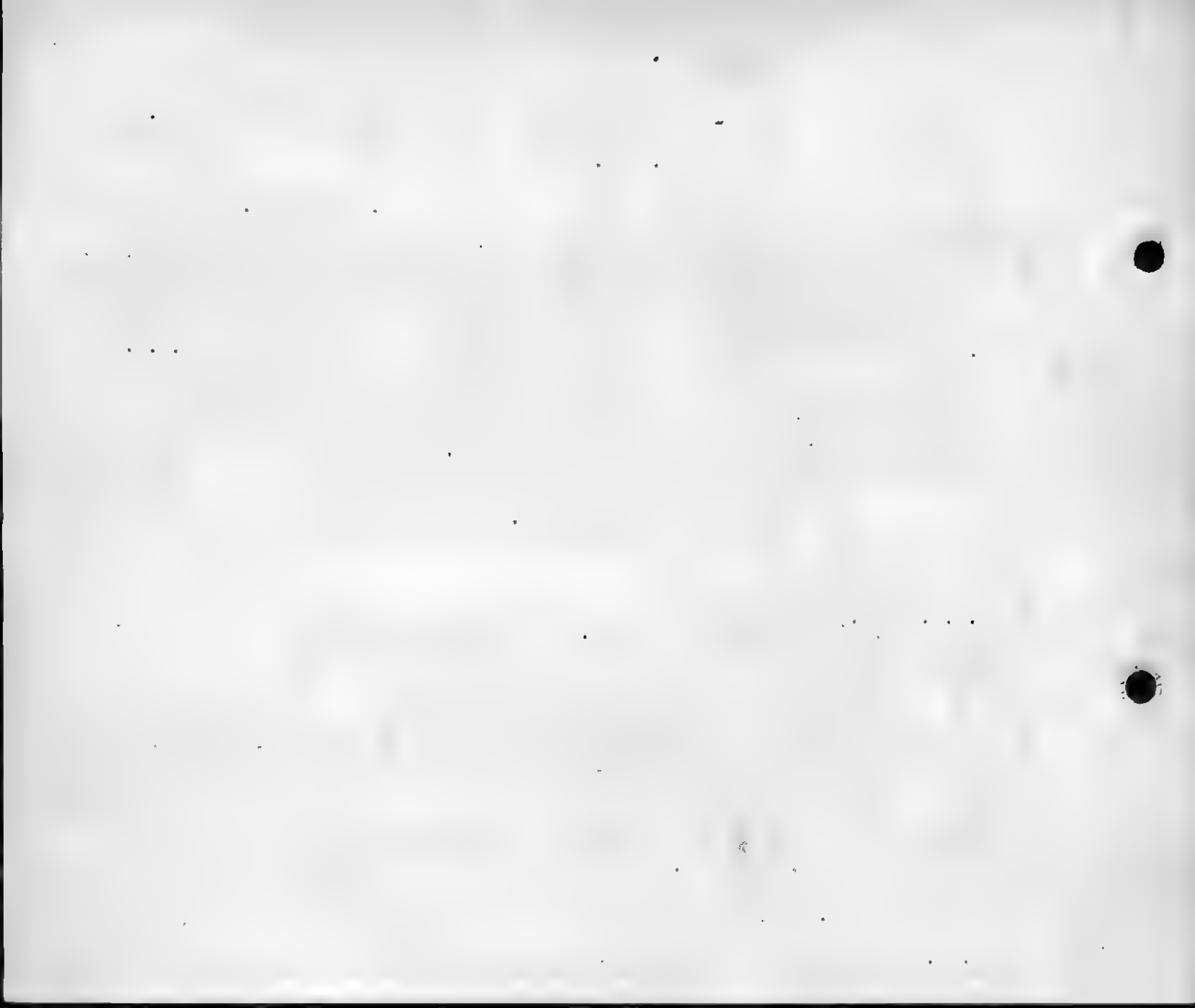
Reg. Dist. No.

01827

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1yr. 6mos. 21days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>231 E. North Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Margaret</u> Last <u>King</u>		4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John King</u>		14. MOTHER'S MAIDEN NAME <u>Mary Unglebow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of food in larynx and bronchi.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>G.B.S. assoc. with disease of unknown or uncertain cause, multiple sclerosis, with psychotic reaction.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Do not know</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u> </u> <u> </u> <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Springfield S. Hosp.</u>		20f. (City or town) (County) (State) <u>Sykesville Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>2/15/60</u>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 18, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 18 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



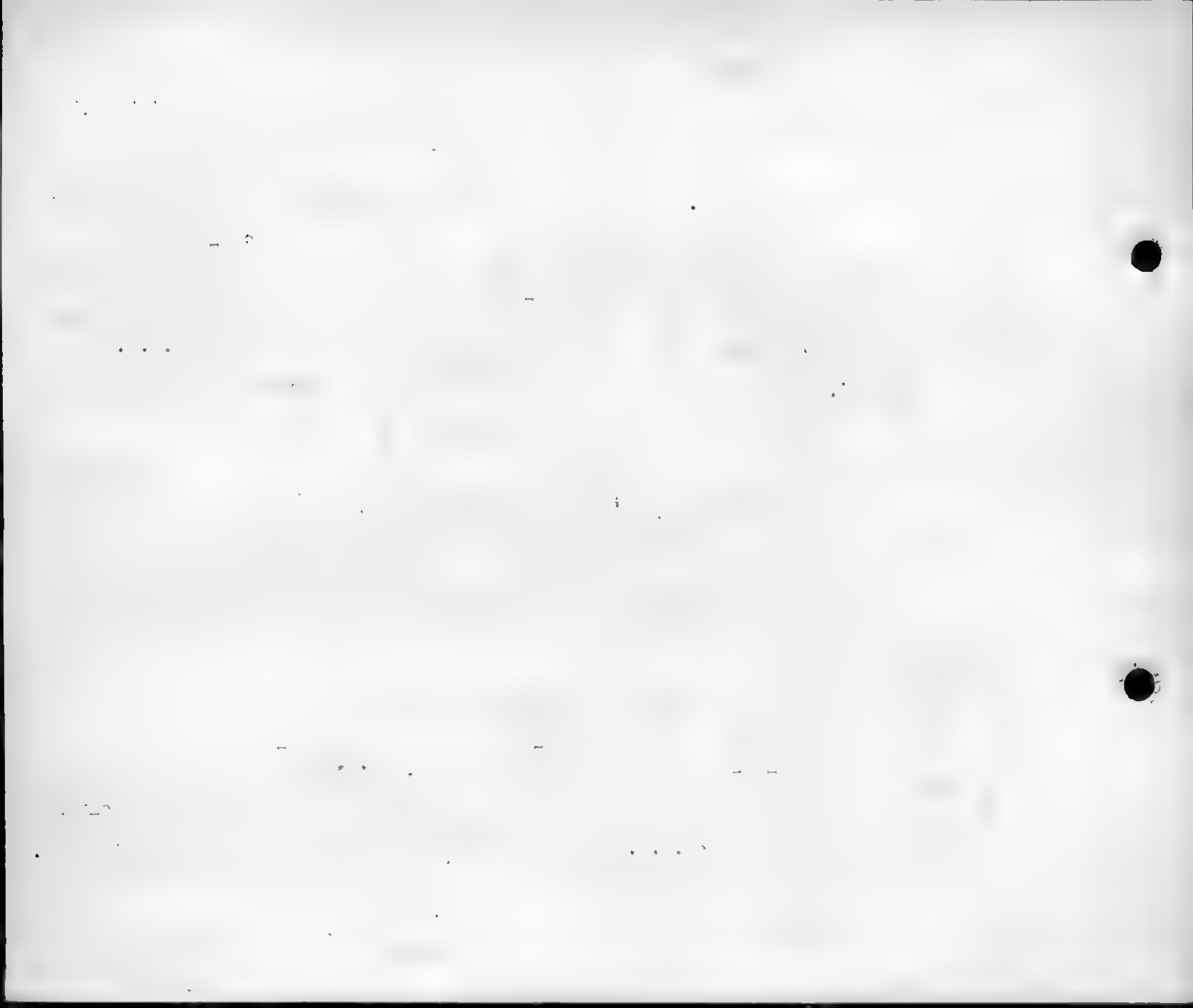
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
1835
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1835
CERTIFICATE OF DEATH

01828

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
d. STREET ADDRESS Route # 2 Middletown		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William ^{First} Elmer ^{Middle} Kinna ^{Last}		4. DATE OF DEATH Month 2 Day 14 Year 1960	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-1874
9 AGE (In years last birthday) yrs 86		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired independent farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David E. Kinna		14. MOTHER'S MAIDEN NAME Mahala Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-14-2141	
17 INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral & Aortic Valve Stenosis 410 DUE TO Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Psychosis with cerebral Arteriosclerosis		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 2-10 1960 , that (I) (we) last saw the deceased alive on 2-14 1960 , and that death occurred at 3:50 A.M. from the causes and on the date stated above.			
22a SIGNATURE Agustin del Campo M.D.		22b DATE SIGNED 2-14-60	
22c PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		22d ADDRESS Springfield State Hospital Sykesville Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 1-17-60	
23c NAME OF CEMETERY OR CREMATORY Luth. Cem. - Church Hill		23d LOCATION (City, town, or county) (State) Myersville, Md. (Rova)	
24 FUNERAL DIRECTOR'S SIGNATURE Arthur H. Mc...		25a REC'D BY REGISTRAR FEB 17 '60	
ADDRESS Middletown		25b. REGISTRAR'S SIGNATURE Arthur E. Kinna	



1
M

1837

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

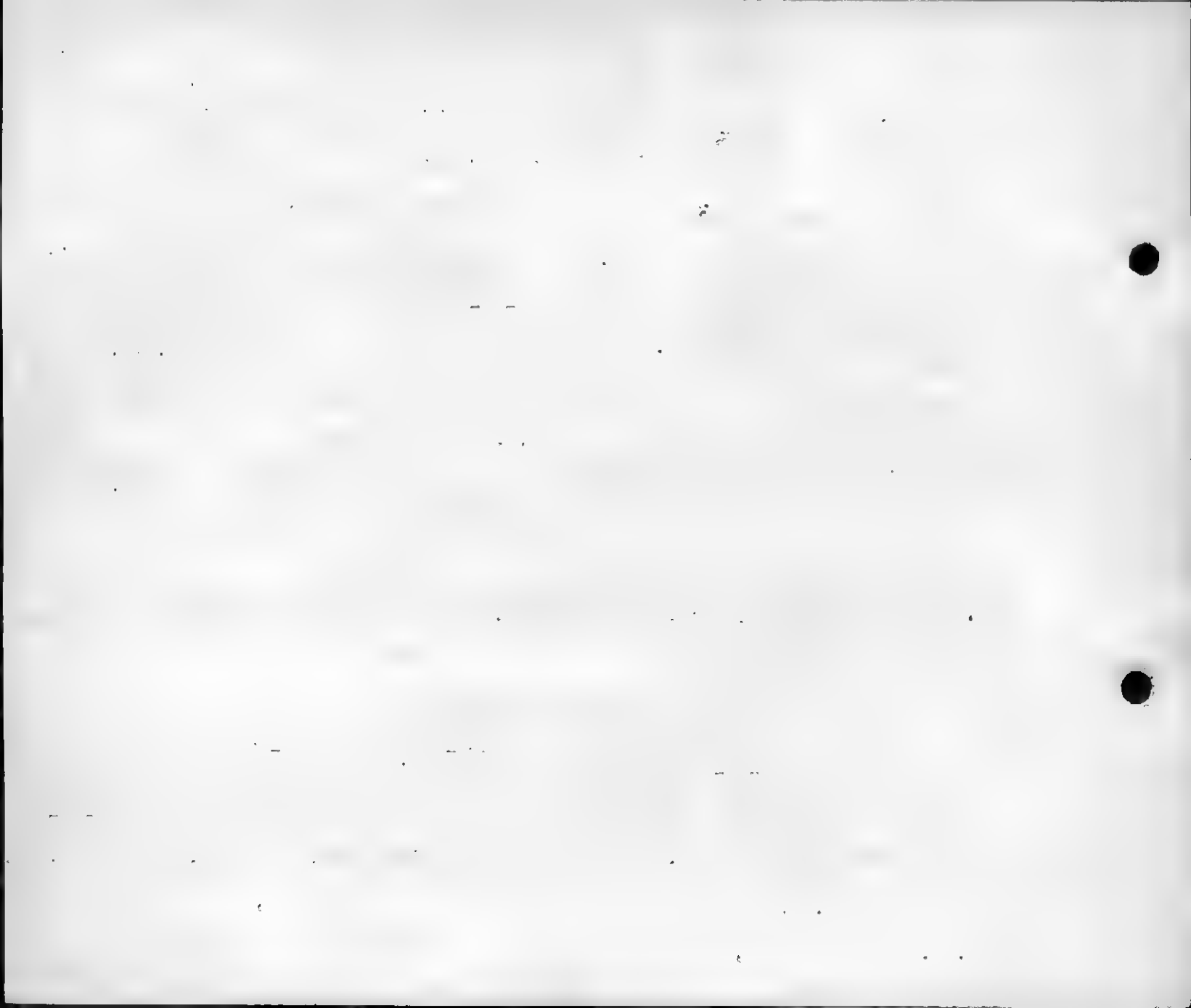
01829

1837 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 30 y 1 m 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
		f. STREET ADDRESS 115 East 4th Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Krepps		4. DATE OF DEATH Month 2 Day 12 Year 1960	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-68
9. AGE (In years lost birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 10 Days 11 Hours 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Garber		14. MOTHER'S MAIDEN NAME Isabelle Brightwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT S.S. Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombocytpenic purpura 276X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2-12-1960 DUE TO (c) 10-20-1960 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, depressed type.			INTERVAL BETWEEN ONSET AND DEATH years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 10 a. m. 20 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20-1960 to 2-12-1960 , that (I) (we) lost 2-12-1960 the deceased alive on 2-12-1960 , and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Edmund Lusthaus M.D.		22b. DATE SIGNED 2-13-60	
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR FEB 16 '60	
		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1838

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

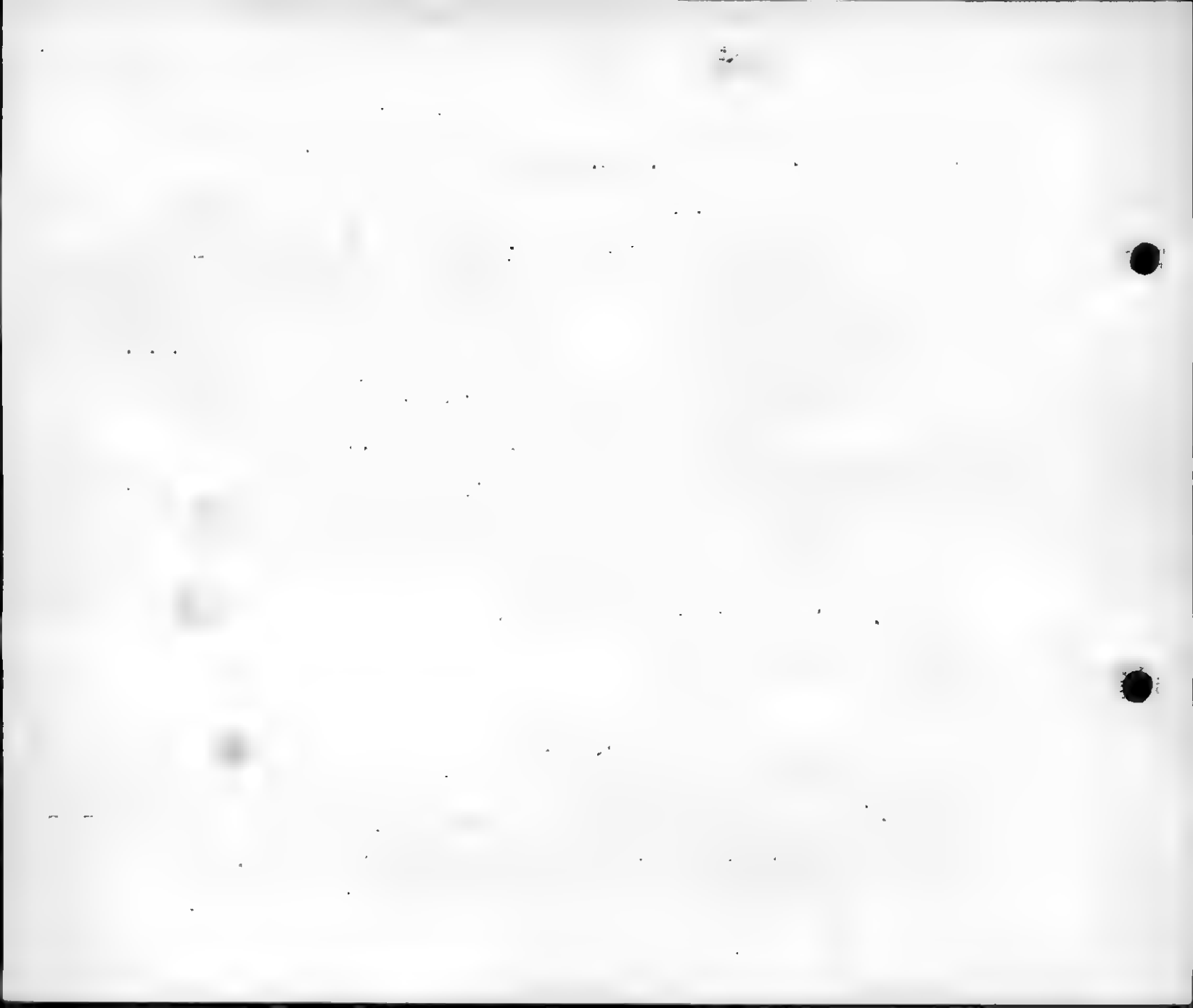
Reg. Dist. No.

01830

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville c. LENGTH OF STAY IN 1b 7yr. 10Mo. 24days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 d. STREET ADDRESS 505 Lee Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Elfreda Last KUNKELY		4. DATE OF DEATH Month 2 Day 13 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-95
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - OFFICE Work-RET		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rhienhold Roessler		14. MOTHER'S MAIDEN NAME Elfreda Amanda Vogel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 04-22-7645 INFORMANT Hospital records. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with disturbance of metabolism, presenile psychotic reaction			INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-20- , 19 54 to 2-13- , 19 60 that I last saw the deceased alive on 2-13- , 19 60 , and that death occurred at 12-40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 2-13-60 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 15 Feb 1960	22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	22d. LOCATION (City, town, or county) (State) BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. B. Walters ADDRESS Pratt & Stricker AS		24a. REC'D BY REGISTRAR FEB 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1839

CERTIFICATE OF DEATH

Reg. Dist. No.

01831

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>44 BROOKFIELD-MANOR-NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR FRANCIS LAMBERT</u>				4. DATE OF DEATH Month Day Year <u>FEB 4 1960</u>			
5. COLOR <u>WHITE</u>		6. COLOR OR RACE <u>MALE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 JULY 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-OWNER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>FRANK LAMBERT</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET METZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>819-36-0914</u>			
17. INFORMANT <u>MRS. EARL HOFF</u>				Address <u>NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12/1/58</u> , 19____, to <u>2/4/60</u> , 19____, that I last saw the deceased alive on <u>2/4/60</u> , 19____, and that death occurred at <u>7:25 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D. <u>New Windsor, Md</u> <u>2/4/60</u> PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u> <u>NEW WINDSOR MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Shultz</u>				ADDRESS <u>New Windsor, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 01832

1840

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Penna. b. COUNTY Adams	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover, Pa. R. D. 1	
c. LENGTH OF STAY in 1b 3 Months		d. STREET ADDRESS Hanover, Pa. R. D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll County Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Horatio Middle D. Last Leese		4. DATE OF DEATH Month 2/ Day 11/ Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/1882
9. AGE (In years last birthday) yrs 77		IF UNDER 1 YEAR: Months 7 Days 5 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Leese		14. MOTHER'S MAIDEN NAME Mary Ellen Fridinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Roy D. Leese, Westminster, Md. R. D. 2		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asthma DUE TO (c) Unknown cause		INTERVAL BETWEEN ONSET AND DEATH Chronic Chronic
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

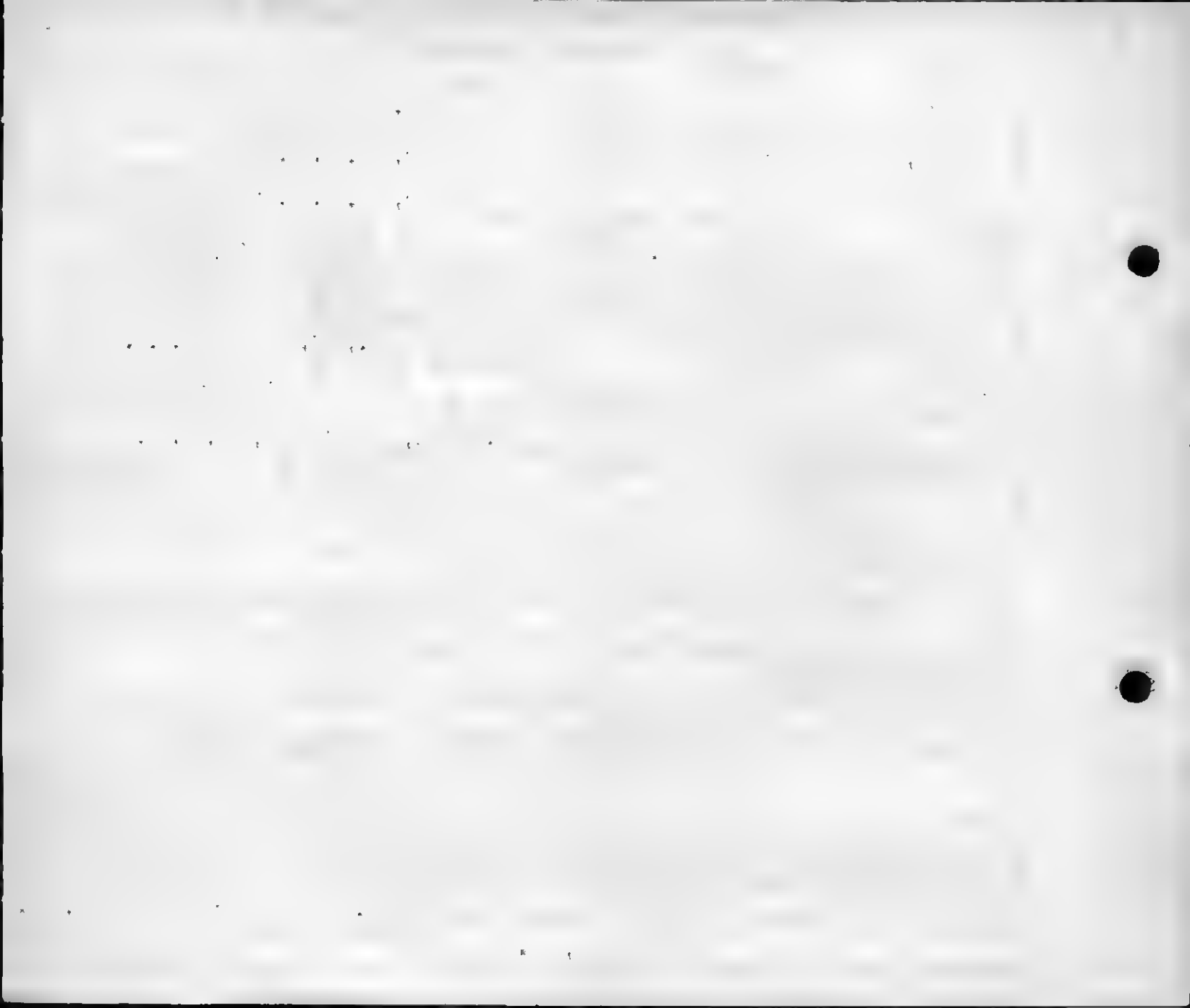
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 - 1 - 1959, to 2 - 11 - 1960, that I last saw the deceased alive on 2 - 10 - 1960, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE W. C. Stone	M.D. 121 E. Queen St. Westminster	DATE SIGNED 2-11-1960
PHYSICIAN'S NAME (Type) W. C. STONE		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/13/60	22c. NAME OF CEMETERY OR CREMATORY Bachmans Valley Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		24a. REC'D BY REGISTRAR DATE FEB 15 '60	24b. REGISTRAR'S SIGNATURE Charles L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



1841

CERTIFICATE OF DEATH

01833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenmount</i> c. LENGTH OF STAY IN 1b <i>15 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>✓</i>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenmount</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) <i>WALTER-BROOKE-LEISTER</i> First Middle Last		4. DATE OF DEATH <i>Feb 1, 1960</i> Month Day Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-23-1884</i> 9. AGE (In years last birthday) <i>75 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	

13. FATHER'S NAME <i>Zephaniah Leister</i>		14. MOTHER'S MAIDEN NAME <i>Isabella Galbreith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-14-1926</i>	
17. INFORMANT <i>Sela Hofeld Leister</i>		Address <i>Greenmount Md</i>	

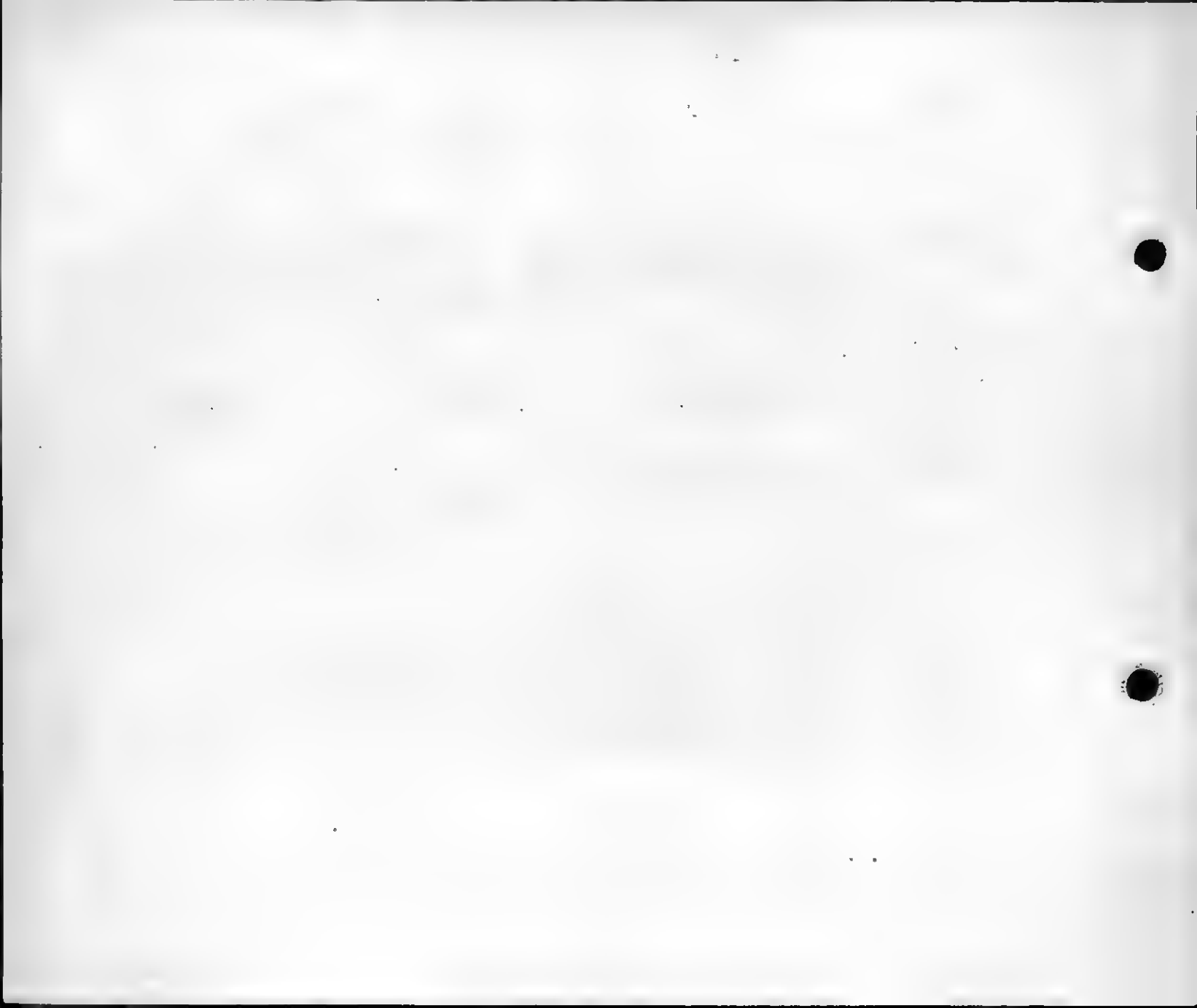
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sub-Arachnoid Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>
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PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from <i>1/29/60</i> , 19, to <i>2/1/60</i> , 19, that I last saw the deceased alive on <i>2/1/60</i> , 19, and that death occurred at <i>10:40 PM</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>M.C. Porterfield</i> PHYSICIAN'S NAME (Type) <i>M.C. Porterfield, M.D.</i>	ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i> DATE SIGNED <i>2/2/60</i>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-5-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Leister</i>	22d. LOCATION (City, town, or county) (State) <i>Carroll Co Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw A Tipton</i> ADDRESS <i>Hampstead Md</i>		24a. REC'D BY REGISTRAR <i>FEB 5 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hines</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

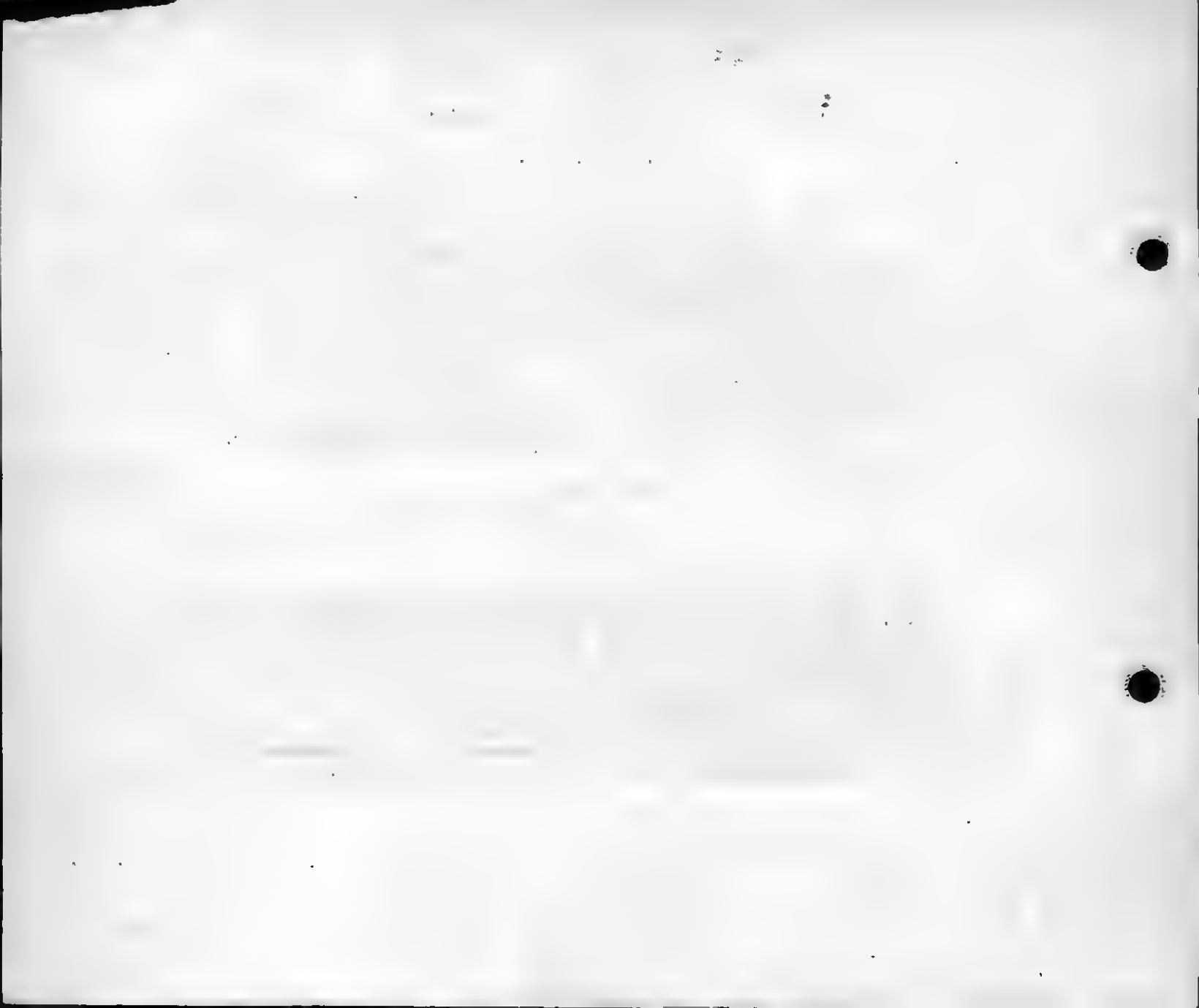
1842

1842

CERTIFICATE OF DEATH

01854

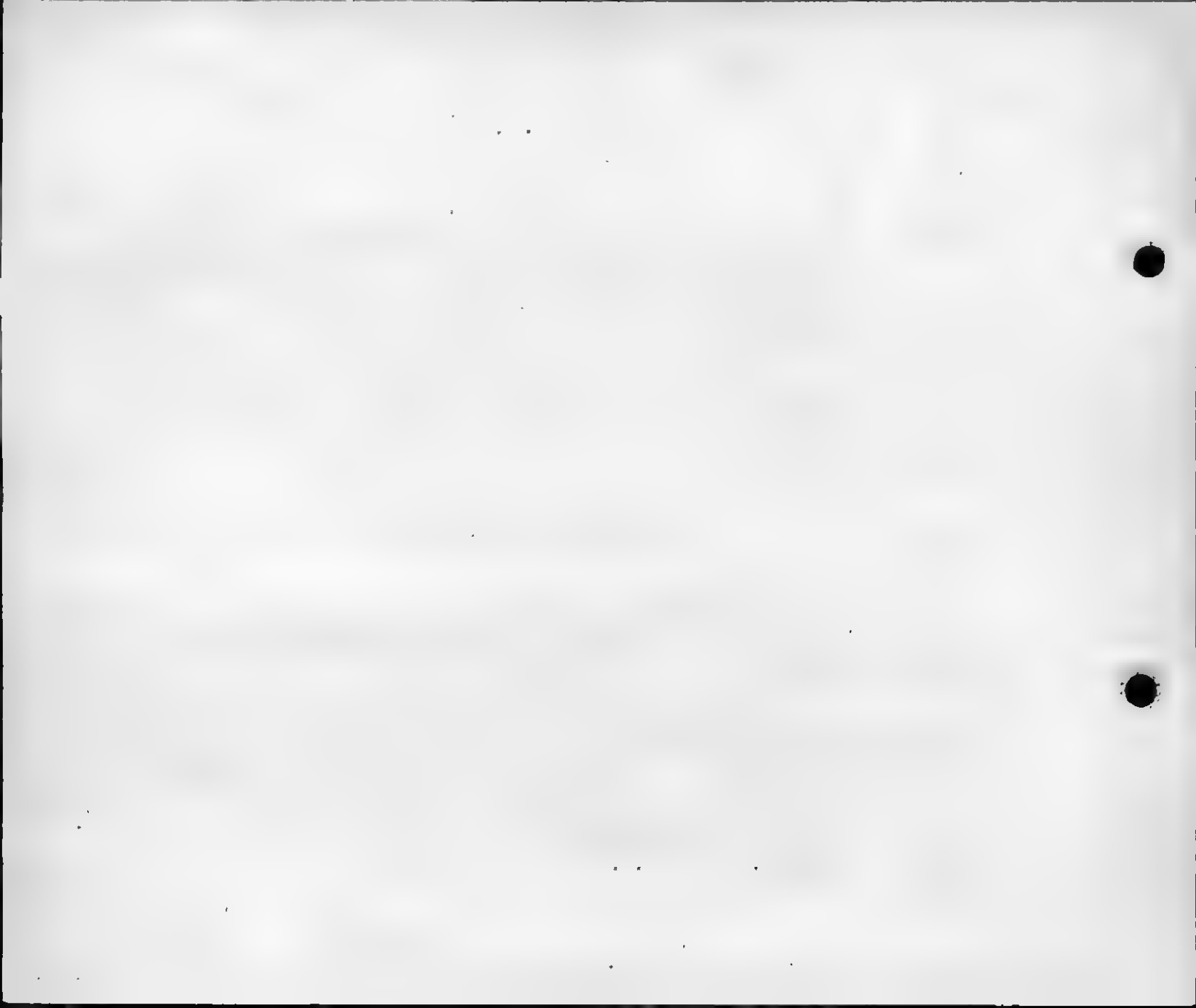
1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 7 mo. 27 d		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 915 East Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Anna Middle Rubin Last Levitz		4. DATE OF DEATH Month February Day 3 Year 1960		5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1876		9. AGE (In years last b rthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Isroel M. Rubin		14. MOTHER'S MAIDEN NAME Not known		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital Records		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH days		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from June 6, 1958 to February 3, 1960 , that (I) (we) last saw the deceased alive on February 2, 1960 , and that death occurred at 7:08 A.M. from the causes and on the date stated above.		22a. SIGNATURE Edmund Lusthaus M.D.		22b. DATE SIGNED 2/3/60		22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.		23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-60		23c. NAME OF CEMETERY OR CREMATORY Herring Run		23d. LOCATION (City, town, or county) _____ (State) _____ Balto Md		24. FUNERAL DIRECTOR'S SIGNATURE Jacel Lewis ADDRESS 2100 Eutaw Place		25a. REC'D BY REGISTRAR FEB 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mths -15 days Baltimore 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 : 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 817 N. Eutaw Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GRACE WELLMAN LOVELL				4. DATE OF DEATH Month Day Year 2 10 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/84		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Lyman Lovell				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion, acute 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease, reaction with psychotic						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 8/25/59 , 19____, to 2/10/60 , 19____, that I last saw the deceased alive on 2/10/60 , 19____, and that death occurred at 7:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrude M. Gross, M.D.		ADDRESS (Street, city or town, state) Sykesville, Md.		DATE SIGNED 2/10/60			
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.		ADDRESS Springfield State Hospital					
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-12-60		22b. DATE THEREOF 2-12-60		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell		ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR DATE FEB 15 '60		24b. REGISTRAR'S SIGNATURE Wm. S. Rouse	

VS A15 (4)
15M 10/57



515

MEDICAL CERTIFICATION

01836

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 19Y 8M 1D		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Erma			4. DATE OF DEATH Last Lupton Month February Day 2 Year 1960		
5. SEX Female			6. COLOR OR RACE white		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH January 2, 1900		
9. AGE (In years last birthday) 60 yrs			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher		
11. BIRTHPLACE (State or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edwind S. Lupton			14. MOTHER'S MAIDEN NAME Clara M. Wyckoff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO None		
17. INFORMANT Springfield Hospital records			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic rheumatic heart disease DUE TO acute systitis (b) acute systitis DUE TO acute systitis (c) acute systitis		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		
21. I certify that (I) (this hospital) attended the deceased from May 31, 1960, to February 2, 1960, that (I) (we) lost saw the deceased alive on February 1, 1960, and that death occurred at 7:10 A.M. from the causes and on the date stated above			22a. SIGNATURE Edmund Lusthaus M.D.		
22b. DATE SIGNED 2/3/60			22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		
22d. ADDRESS Springfield Hospital, Sykesville, Md.			23a. REC'D BY REGISTRAR DATE FEB 9 '60		
23b. REGISTRAR'S SIGNATURE Arthur S. Kline			23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		
23d. LOCATION (City, town, or county) (State) Baltimore, Maryland			23e. DATE THEREOF Removal 2/4/60		
23f. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Narford Road #14			23g. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		



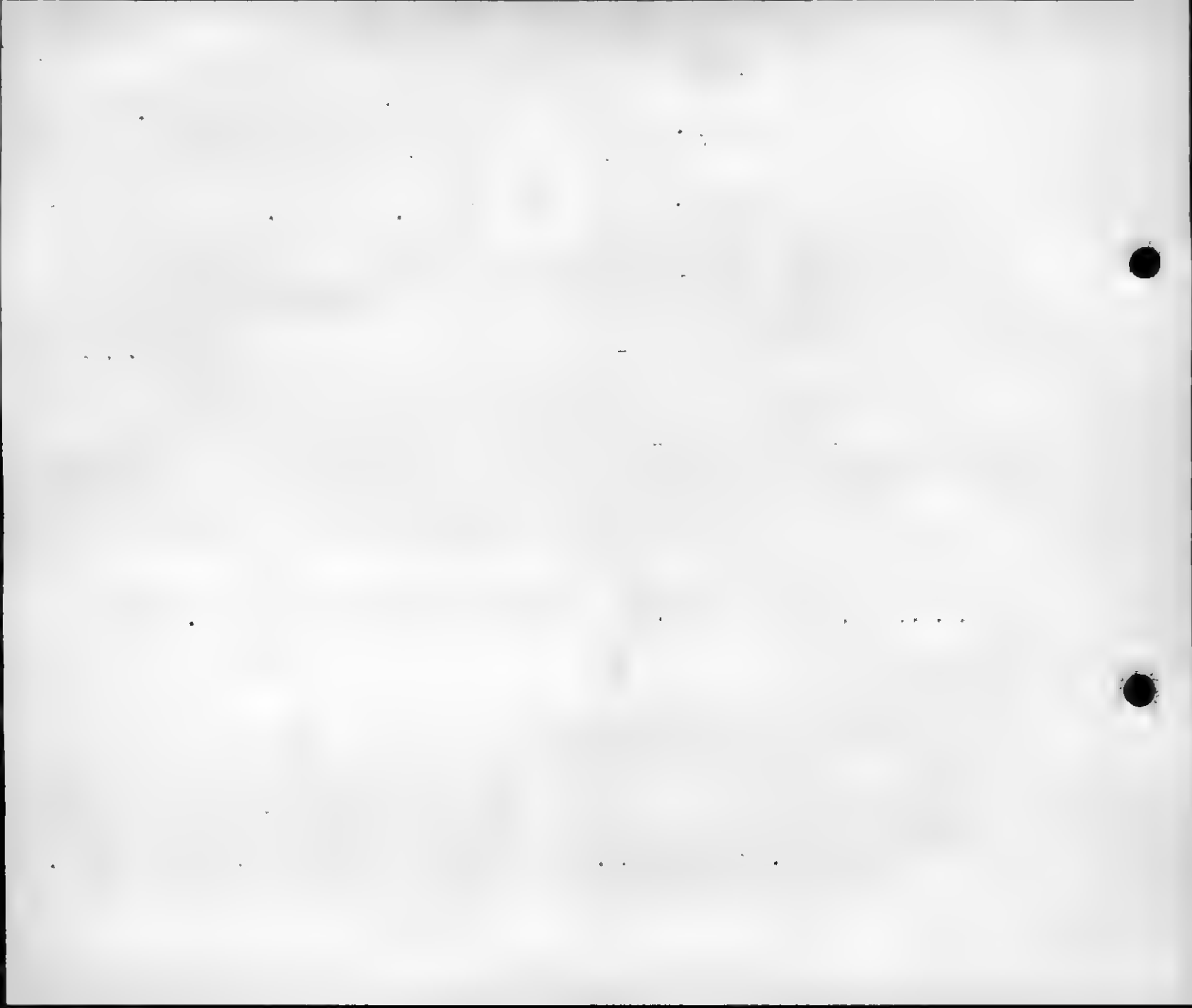
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01887

1845 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN lb 22 days		d. STREET ADDRESS 1731 N. Charles St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle Gertrude Last Litteston Matthews		4. DATE OF DEATH Month February Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1893
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min 67	11. IF UNDER 24 HRS Months 67 Days 67 Hours 67 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Litteston		14. MOTHER'S MAIDEN NAME Frances Valentine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic heart disease with aortic stenosis 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction. INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 11, 1960 to February 3, 1960 , that (I) (we) last saw the deceased alive on February 3, 1960 , and that death occurred on February 3, 1960 from the causes and on the date stated above.			
22a. SIGNATURE Ellis S. Margolin		22b. DATE SIGNED 2/4/60	
22c. PHYSICIAN'S NAME (Type) Ellis S. Margolin, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 2/6/60	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City, town, or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Luck		25a. REC'D BY REGISTRAR FEB 9 '60	
25b. REGISTRAR'S SIGNATURE William L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

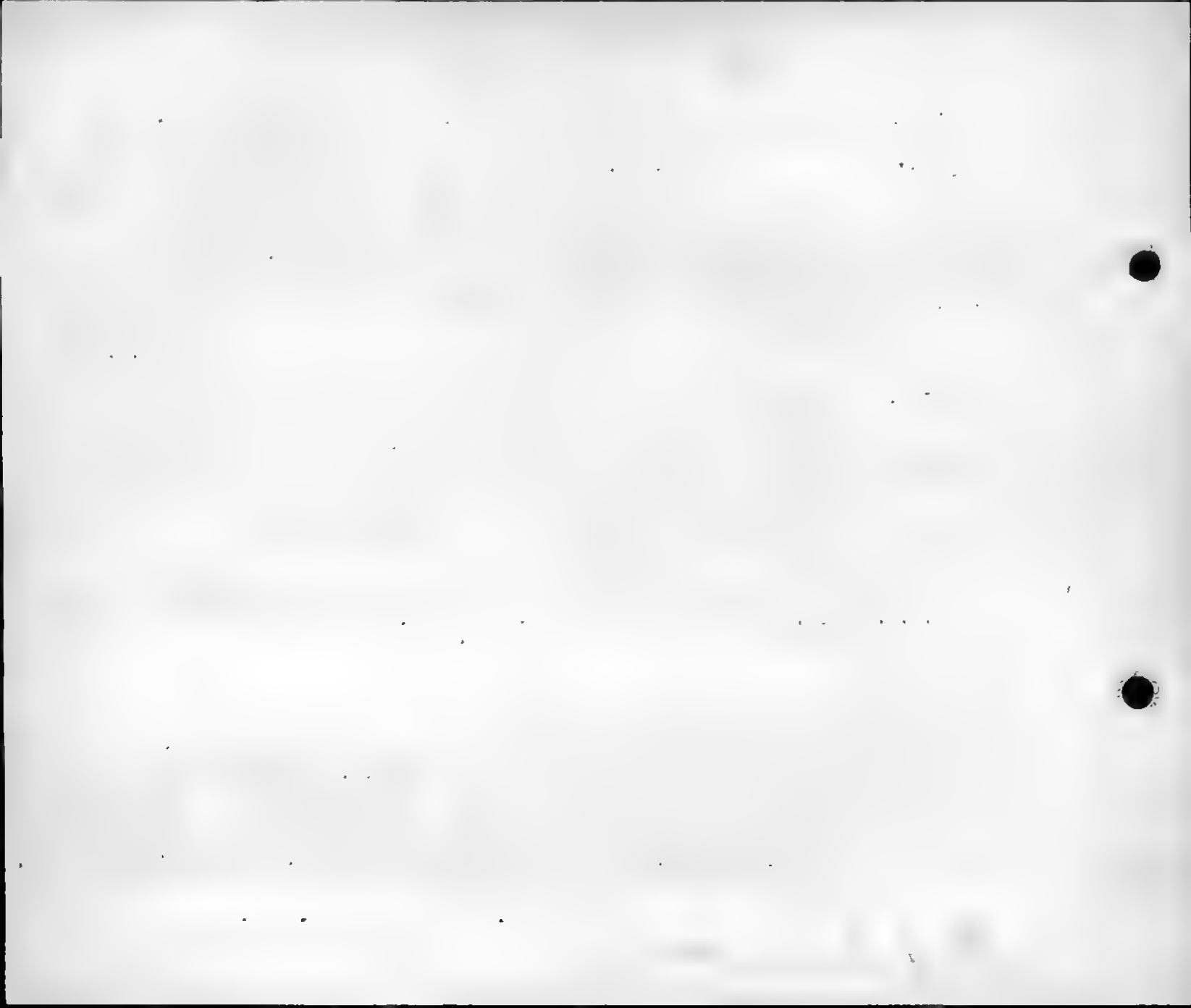
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1846

01838

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4yr.7mo.12days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3605 White Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Margaret Middle Gertrude Last Miller				4. DATE OF DEATH Month February Day 10 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1874		9. AGE (In years last birthday) 85 yrs IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Bartlett				14. MOTHER'S MAIDEN NAME Charlotte Bartlett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance, 15.01 with cerebral arteriosclerosis, with psychotic reaction.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from June 28, 1955 to February 10, 1960 that (I) (we) last saw the deceased alive on February 9, 1960, and that death occurred at 5:10 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Edmund Lusthaus				22b. DATE SIGNED 2/10/60		22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.			
22d. ADDRESS Springfield State Hospital, Sykesville, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS Springfield State Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/60		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION (City, town, or county) (State) Balto., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Jackson, Beth. Md.				25a. REC'D BY REGISTRAR DATE FEB 15 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



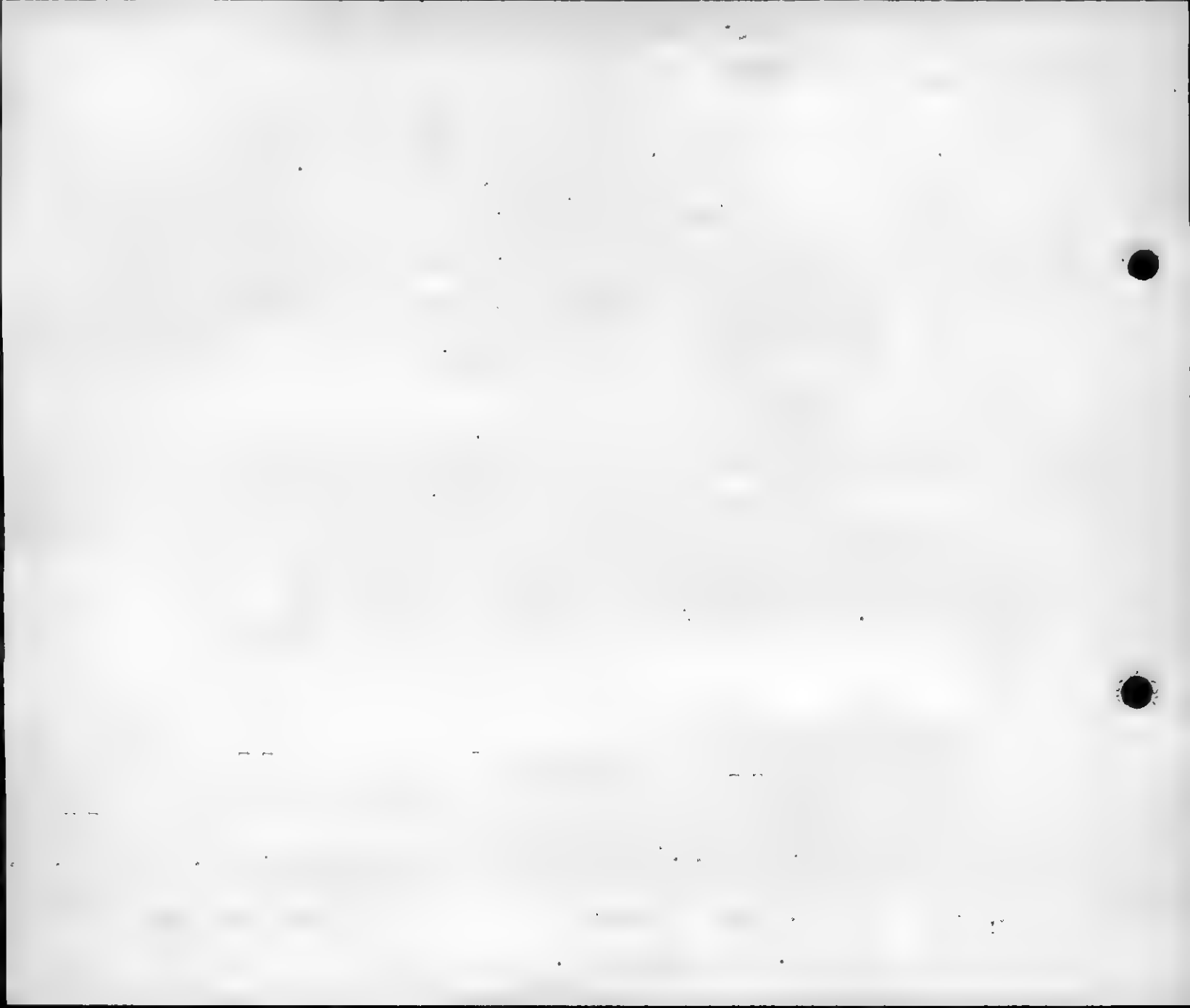
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01853

1847

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31, Md.			
c. LENGTH OF STAY IN 1b 14 days				d. STREET ADDRESS 1617 Lancaster Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine (Katie) Million				4. DATE OF DEATH Month Day Year 2 6 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1879		9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA Naturalized	
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CRS assoc. with senile brain disease metastatic carcinoma							INTERVAL BETWEEN ONSET AND DEATH days
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1-23- 1960 , to 2-6- 1960 , that (I) (we) last saw the deceased alive on 2-6- 1960 , and that death occurred at 11:05 from the causes and on the date stated above.							
22a. SIGNATURE <i>Edmund Lusthaus</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE 2-7-1960	
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				22d. ADDRESS Springfield State Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Ave.				25a. REC'D BY REGISTRAR FEB 11 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

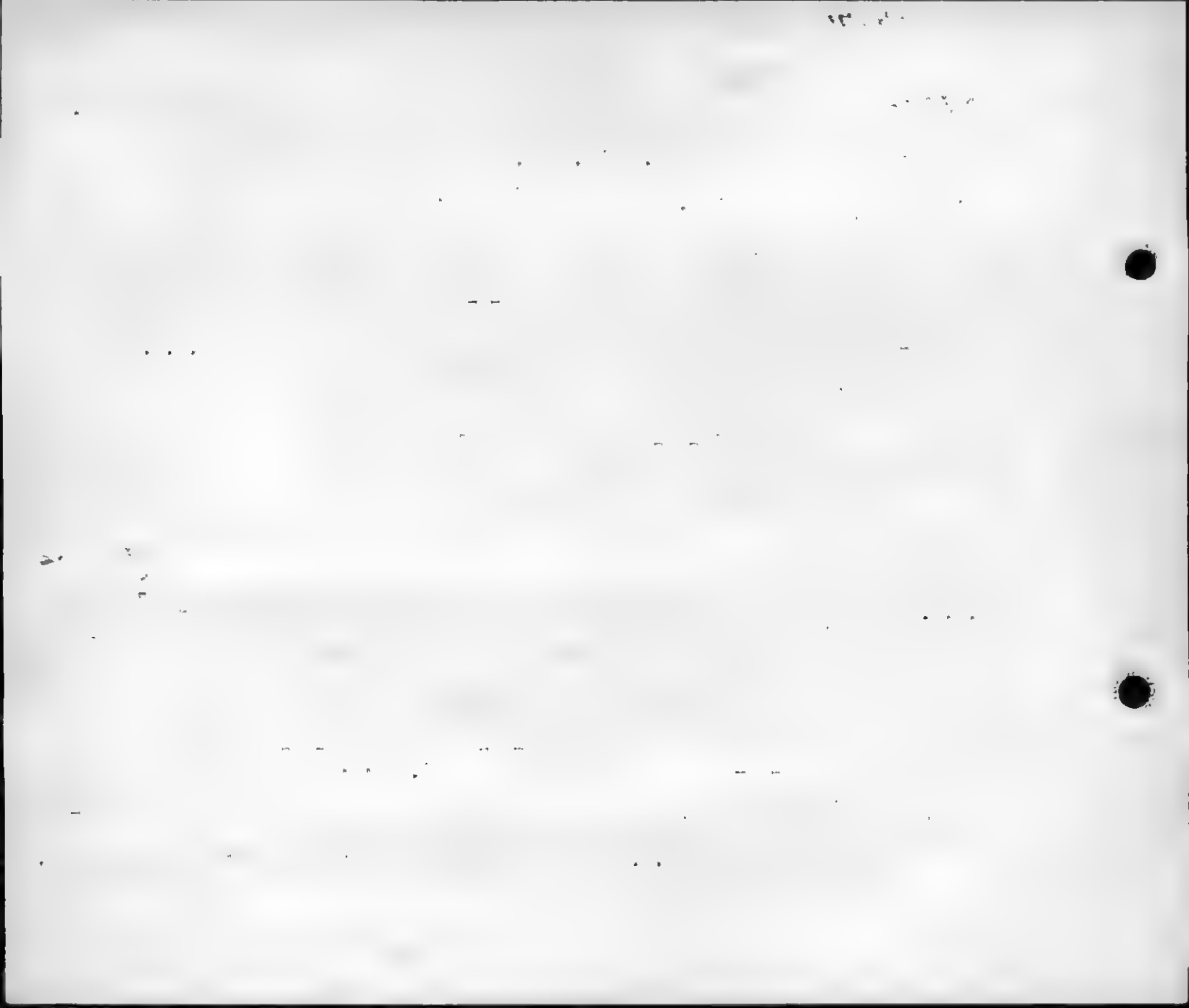
1848

1848

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01840

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery Co. 178			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ken sington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				d. STREET ADDRESS 4113 Franklin Street			
3. NAME OF DECEASED (Type or print) First John Middle William Last Mock				4. DATE OF DEATH Month 2 Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-2-1883	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter-painter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Mock				14. MOTHER'S MAIDEN NAME Mary Bertram			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 228-30-2596		17. INFORMANT Hospital records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 471X (b) DUE TO (c) C.B.S. associated with senile brain disease with psychotic reaction Large infected bed sores				INTERVAL BETWEEN ONSET AND DEATH days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-21- 1957 to 2-28- 1960 , that (I) (we) last saw the deceased alive on 2-28- 1960 , and that death occurred on 2-28- 1960 from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo.				22b. DATE 2-28-60		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Agustin del Campo M.D.				22e. ADDRESS Springfield State Hospital Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 3-1-60		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City, town, or county) (State) Sparks Church, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Hargitt				25a. REC'D BY REGISTRAR DATE MAR 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



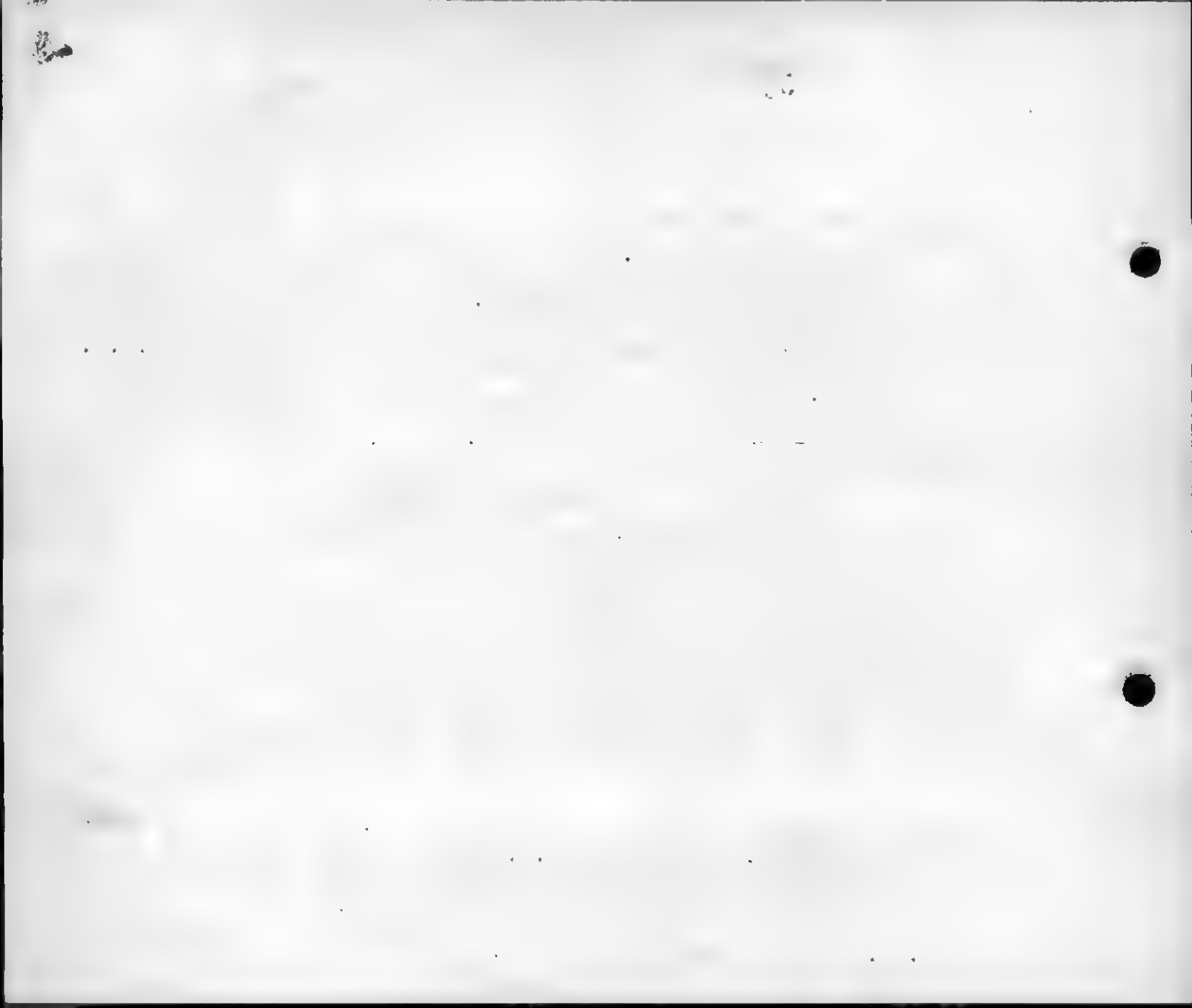
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1849

01841

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle A. Last MOORE				4. DATE OF DEATH Month February Day 27 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1890	
9. AGE (In years last birthday) 69 yrs.		10. UNDER 1 YEAR Months 27 Days 16 Hours 00 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Farming (owner)			
13. FATHER'S NAME Harry L. Moore				14. MOTHER'S MAIDEN NAME Katherine Benard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO 213-36-8172			
17. INFORMANT Mary E. Moore, Woodbine, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Coronary Thrombosis, 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complete heart block, arteriosclerosis. DUE TO (c) 27 Feb 60							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1956 to							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Winfield, Md				20g. (County) Carroll		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 1956 to 27 Feb 1960 , that (I) (we) last saw the deceased alive on 27 Feb 1960 , and that death occurred at 12:30 P M, from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall				22b. ADDRESS Spencerville, Md			
22c. PHYSICIAN'S NAME (Type) Howard E. Hall				22d. ADDRESS M.D. Spencerville, Md			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Airy, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE G. M. WALTZ, Winfield, Maryland				25a. REC'D BY REGISTRAR DATE MAR 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



CERTIFICATE OF DEATH

Reg. Dist. No.

01842

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS Route #2	
3. NAME OF DECEASED (Type or print) First Isaac Middle Isaac Last Moore		4. DATE OF DEATH Month February Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-1889
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Snow Hill, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac Showell		14. MOTHER'S MAIDEN NAME Bell West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 221-24-9569	
17. INFORMANT Katie Stevenson - Daughter		Address Katie Stevenson - Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002X DUE TO Far advanced bilateral cavitory pulmonary TB Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Pulmonary emphysema DUE TO (c) Pulmonary emphysema		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15 , 19 58 to February 20 , 19 60 , that I last saw the deceased alive on February 20 , 19 60 , and that death occurred at 5:15 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. M. Maculans M. D.		ADDRESS (Street, city or town, state) Henryton, Maryland	
DATE SIGNED 2-20-60			
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		Henryton State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-25-1960		22b. DATE THEREOF 2-25-1960	
22c. NAME OF CEMETERY OR CREMATORY LONG		22d. LOCATION (City, town, or county) (State) SELBYVILLE DEL.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert William Elmer City Md		ADDRESS SELBYVILLE DEL.	
24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1801

CERTIFICATE OF DEATH

01843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Davis Apartments</u>		e. STREET ADDRESS <u>Cor. Main & John St.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN FRANKLIN MOORE</u>		4. DATE OF DEATH Month <u>Feb</u> , Day <u>16</u> , Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Black & Black (Guard)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Berwick, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Moore</u>		14. MOTHER'S MAIDEN NAME <u>Anna Seely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO <u>218-24 7958</u>	
17. INFORMANT <u>Mrs. Ruthanna W. Moore</u>		Address <u>Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>110.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of mandible (rd)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS.</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4, 1948</u> to <u>February 16, 1960</u> , that I last saw the deceased alive on <u>Feb 16, 1960</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Julius Chepko</u>		M.D. <u>854 W. Green St</u>	
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>		DATE SIGNED <u>2/17/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 19, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Brook</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster Md</u>	
24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hinkle</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



1851

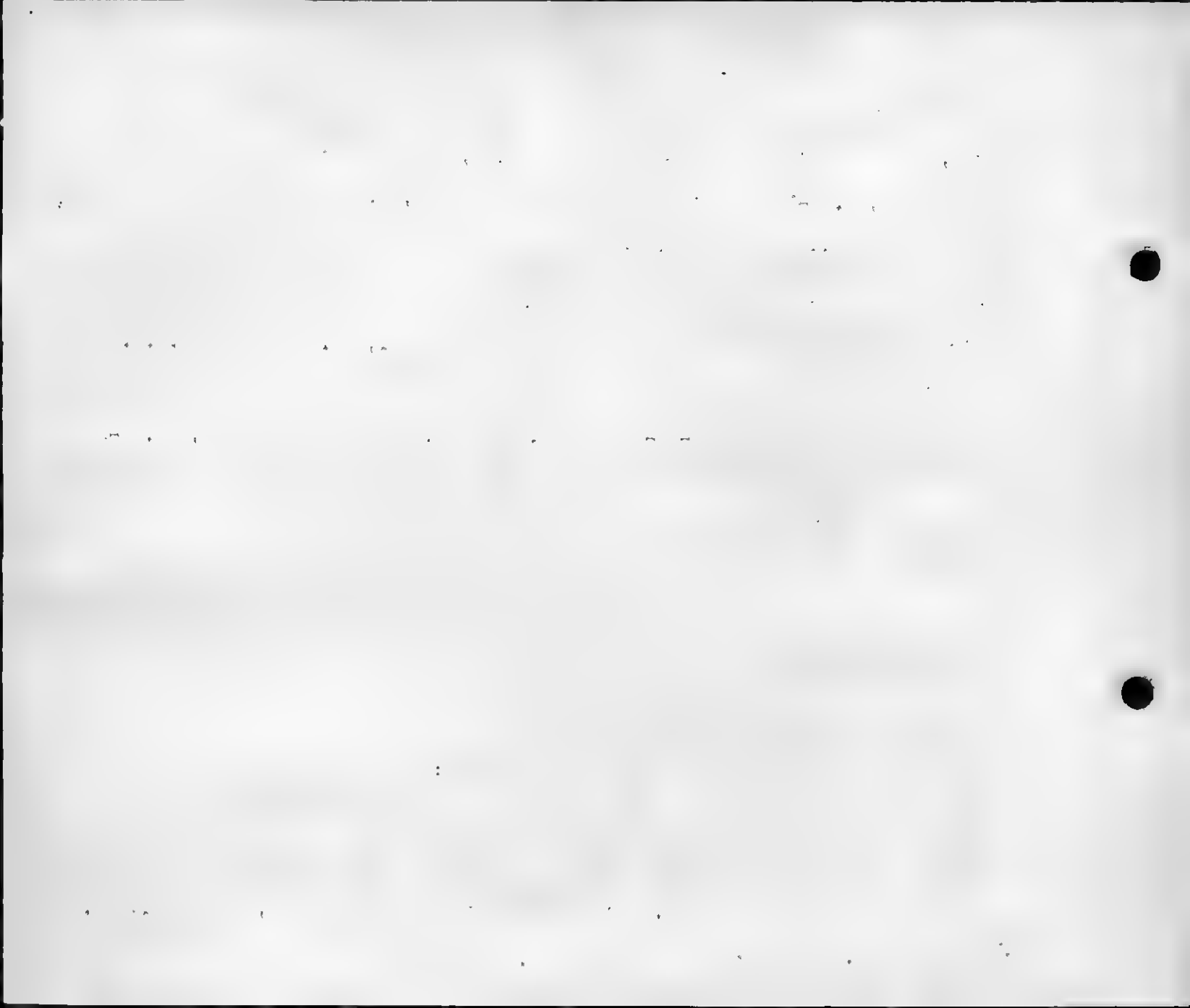
CERTIFICATE OF DEATH

01844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster				c. LENGTH OF STAY IN 1b 30 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R-1 (Silver Run)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Leroy Last Myers				4. DATE OF DEATH Month 2/5/60 Day Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/1883	9. AGE (In years last birthday) yrs 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Myers				14. MOTHER'S MAIDEN NAME Bmaline Humbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-1783		17. INFORMANT Mrs. Harry L. Myers, Westminster, Md. R-1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 10 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Littlestown, Pa.	(County)	(State)		
21. I certify that I attended the deceased from Jan 2, 1960 to Feb 5, 1960 , that I last saw the deceased alive on Feb 5, 1960 , and that death occurred at 7:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 W. King St. Littlestown, Pa. DATE SIGNED 2-6-60 ACTUAL SIGNATURE L. L. Potter M.D. NAME (Type) L. L. POTTER M-D, 12 W KING ST. LITTLESTOWN, PA							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/8/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) Littlestown, Adams Co., Pa.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little			ADDRESS Littlestown, Pa.	24a. REC'D BY REGISTRAR DATE FEB 9 '60	24b. REGISTRAR'S SIGNATURE Colbert S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01845

1852

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine c. LENGTH OF STAY IN 1b 3 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weitzel Nursing Home		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy X d. STREET ADDRESS 1	
3 NAME OF DECEASED (Type or print) MERTIE First L. Middle PENN Last		4. DATE OF DEATH February Month 24, Day 1960 Year	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1880
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Gosnell		14. MOTHER'S MAIDEN NAME Sarah Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Ferris R. Penn, Mt. Airy, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 171X IMMEDIATE CAUSE (a) Carcinoma of Cervix Uteri DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH More than 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1959 to Feb 1960 that I last saw the deceased alive on Jan 25, 1960 , and that death occurred at 4:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Culwell		ADDRESS (Street, city or town, state) 900 So. Main St. DATE SIGNED 2/24/60	
PHYSICIAN'S NAME (Type) W. B. Culwell		M.D. 900 So. Main St., Mt. Airy, Md.	
22a. BURIAL, CREMATION, REMOVAL. (Specify) Burial		22b. DATE THEREOF 2-26-1960	
22c. NAME OF CEMETERY OR CREMATORY Winfield Church of God		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ., Winfield, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE FEB 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01846

1. PLACE OF DEATH a. COUNTY 1853 <div style="text-align: center;">Carroll</div> <div style="text-align: center;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 1853 <div style="text-align: center;">Maryland</div> b. COUNTY 1853 <div style="text-align: center;">Baltimore</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Sykesville</div>		c. LENGTH OF STAY IN TB <div style="text-align: center;">30yrs. 11mos. 6days</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center;">Springfield State Hospital</div>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">Catherine B. Remmells</div>		4. DATE OF DEATH Month Day Year <div style="text-align: center;">February 3, 1960</div>	
5. SEX <div style="text-align: center;">Female</div>	6. COLOR OR RACE <div style="text-align: center;">White</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center;">1902 2-26-1901</div>
9. AGE (In years last birthday) <div style="text-align: center;">58 yrs.</div>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Housework</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">-</div>	
11. BIRTHPLACE (State or foreign country) <div style="text-align: center;">Maryland</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>	
13. FATHER'S NAME <div style="text-align: center;">Daniel Remmells</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Emma Thompson</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <div style="text-align: center;">No -</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">-</div>	
17. INFORMANT Address <div style="text-align: center;">Springfield Hospital Records</div>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x <div style="text-align: center;">Pulmonary edema and bronchopneumonia</div> DUE TO <div style="text-align: center;">Hyperglycemic coma</div> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <div style="text-align: center;">Thrombophlebitis of the right ileac vein</div> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">Days</div> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="text-align: center;">Epilepsy with mental deficiency. Fracture, neck of right femur.</div>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center;">Patient was found lying on floor.</div>	
20c. TIME OF INJURY Month, Day, Year <div style="text-align: center;">9:30 a.m. 1/26/1960</div>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <div style="text-align: center;">Hospital</div>	20f. (City or town) (County) (State) <div style="text-align: center;">Sykesville Carroll Md.</div>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <div style="text-align: center;">James T. Marsh</div>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <div style="text-align: center;">James T. Marsh, M.D.</div>		DATE SIGNED <div style="text-align: center;">2/4/60</div>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>	22b. DATE THEREOF <div style="text-align: center;">2-6-1960</div>	22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Poplar Grove Cemetery</div>	22d. LOCATION (City, town, or county) (State) <div style="text-align: center;">Cockeysville Md.</div>
23. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center;">Brooks Funeral Service</div>		24a. REC'D BY REGISTRAR <div style="text-align: center;">FEB 8 '60</div>	
ADDRESS <div style="text-align: center;">Towson 4, Md.</div>		24b. REGISTRAR'S SIGNATURE <div style="text-align: center;">Charles S. Kline</div>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

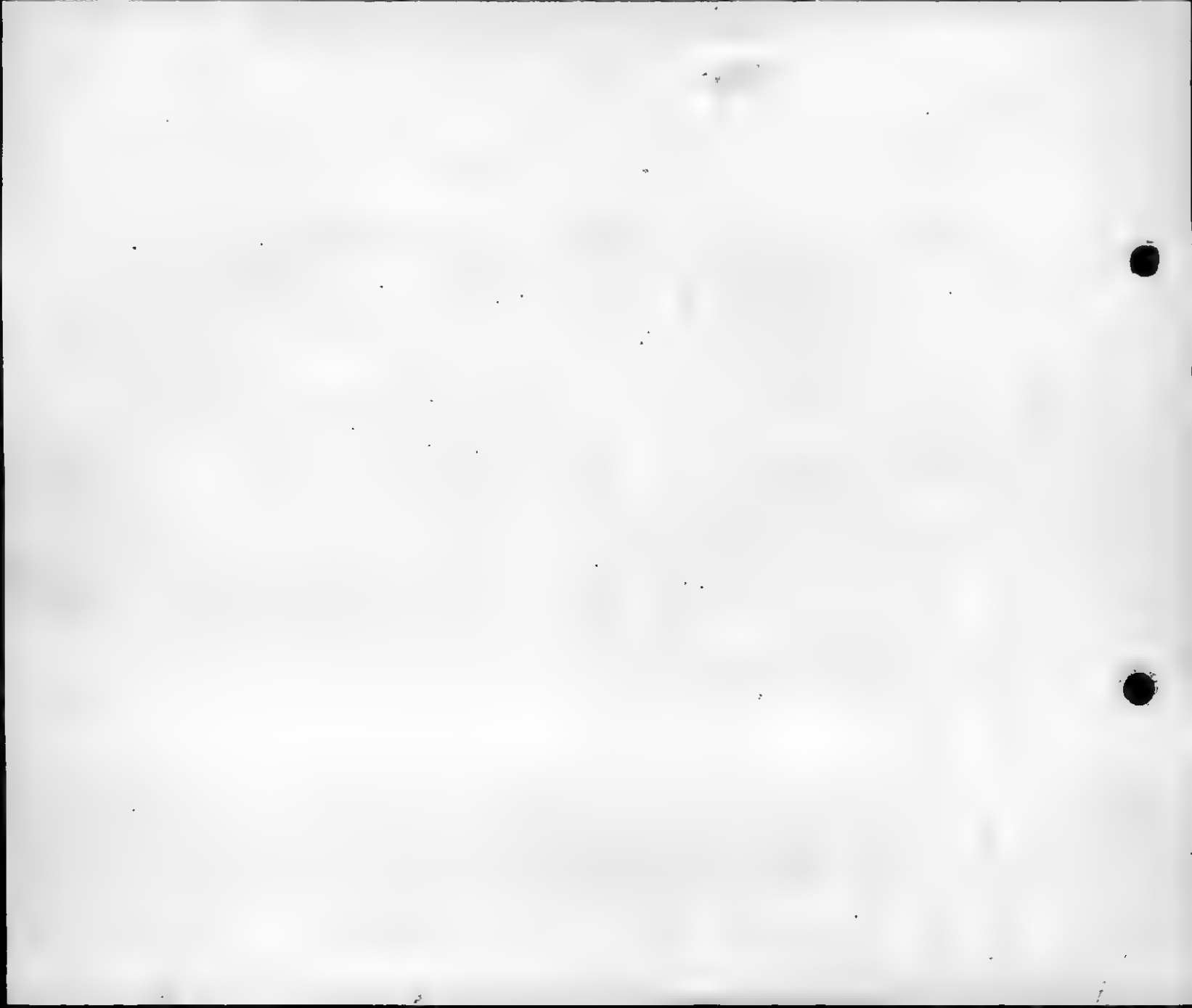


TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01847

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North-Hycksville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLEN PEACE REYNOLDS</u>		4. DATE OF DEATH <u>Feb. 17 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John T. Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Belt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>817-12-2776</u>	
17. INFORMANT <u>Mrs. Ellen H. Reynolds</u>		Address <u>Hycksville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Coronary Arteriosclerosis,</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized. Hypertension</u> DUE TO (c) <u>Influenza</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1956</u> <u>to</u> <u>17 Feb 60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>17 Feb</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>17 Feb 1960</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>2-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		22d. ADDRESS <u>Hycksville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-26-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woods Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hought</u>		25a. RECORD BY REGISTRAR <u>Feb 23 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hantz</u>			



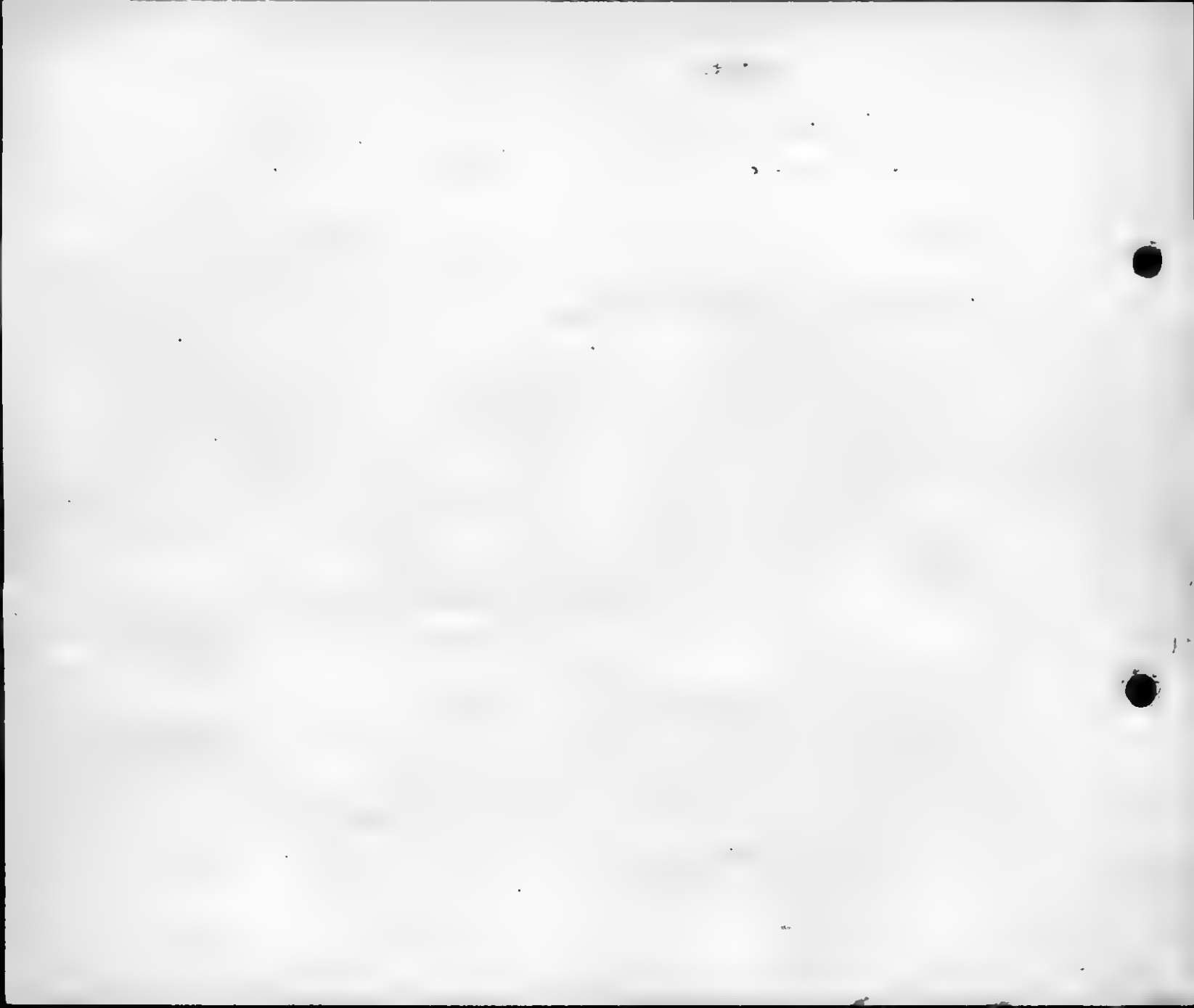
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01848

1855

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest - Sykesville</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>ROSIE</u> First <u>LEE</u> Middle <u>RHIZ</u> Last <u>BOTTOM</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1960</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 13, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William - Powers</u>				14. MOTHER'S MAIDEN NAME <u>Eugenia Harry</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mr. Edward Harry - Sykesville, Md.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 446X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Per. heart failure</u> DUE TO _____ (c) <u>14 year tension, Arteriosclerosis</u> DUE TO _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <u>Feb. 7, 1960</u> to <u>Feb. 7, 1960</u> that (I) (we) last saw the deceased alive on <u>Feb. 8, 1960</u> and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.							
22a SIGNATURE <u>Sam O. Truman</u> M.D.				22b. DATE SIGNED <u>2/10/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sam O. Truman</u>				22d. ADDRESS <u>Sykesville, MD.</u>			
23a BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b DATE THEREOF <u>2-11-60</u>		23c NAME OF CEMETERY OR CREMATORY <u>Burial Park</u>		23d LOCATION (City, town, or county) <u>Croftville, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Wright</u> ADDRESS _____				25a REC'D BY REGISTRAR <u>FEB 12 '60</u>		25b. REGISTRAR'S SIGNATURE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1 **M**

1856

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01843

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 yrs 4m 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle E Last Riley		4. DATE OF DEATH Month 2 Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-19-01
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 1 Days 7 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harman A. Riley		14. MOTHER'S MAIDEN NAME Katherine Moran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.0 IMMEDIATE CAUSE (a) Arteriosclerotic hypertensive heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with chronic alcoholism			
INTERVAL BETWEEN ONSET AND DEATH years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20-1954 to 2-7-1960 that (I) (we) last saw the deceased alive on 2-7-1960 and that death occurred at 2:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Edmund Lusthaus M.D.		22b. DATE 2-7-60	
22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/60	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town or county) (State) Rt. 1, Sykesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas A. J. K... ..		25a. REC'D BY REGISTRAR FEB 9 '60	
ADDRESS ...		25b. REGISTRAR'S SIGNATURE Arthur S. K...	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> 1857 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAIN ST</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS <u>MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PRESTON BAILE ROOP</u>			4. DATE OF DEATH Month Day Year <u>FEB. 9 1960</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>20 FEB. 1886</u>			
9. AGE (In years last birthday) <u>73 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER - REAL ESTATE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN H. ROOP</u>			
14. MOTHER'S MAIDEN NAME <u>ANNIE DEVILBISS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-14-9130</u>			
17. INFORMANT <u>MRS. NETTIE B. ROOP, NEW WINDSOR MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James T. Marsh</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>2/9/60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12 FEB 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>			
22d. LOCATION (City, town, or county) _____		(State) _____		24a. REC'D BY REGISTRAR <u>FEB 12 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>John S. Wilson</u>		24c. REGISTRAR'S SIGNATURE <u>John S. Wilson</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital and the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

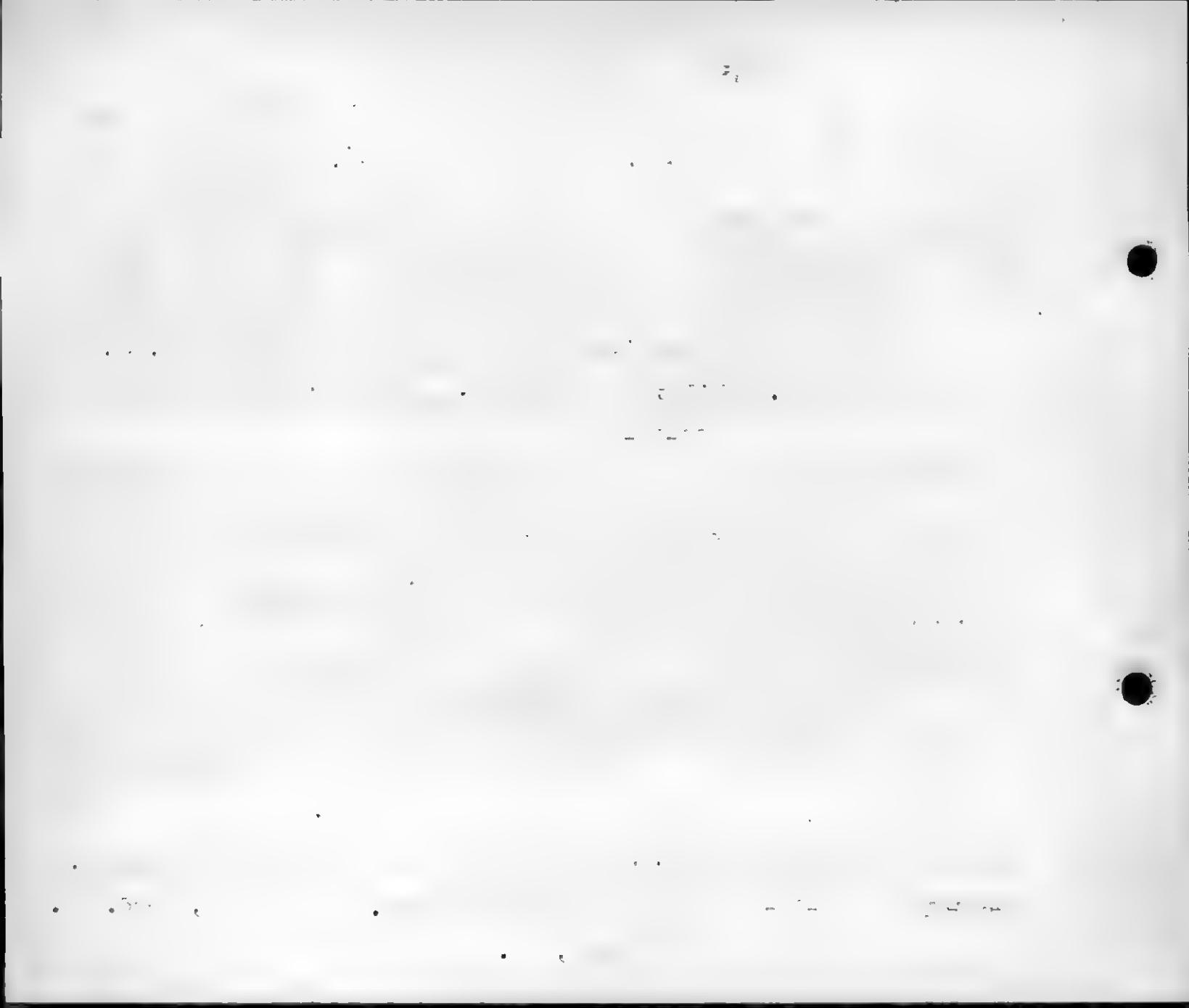
1858

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01851

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 mos. 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Silas Clayton Schildt				4. DATE OF DEATH Month February Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 31, 1878	
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 8 Days 12 Hours 15 Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Lime Plant			
13. FATHER'S NAME David W. Schildt				14. MOTHER'S MAIDEN NAME Elizabeth Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO 213-10-2112		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of right foot 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Peripheral arteriosclerosis DUE TO (c) Generalized arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH Months Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.D.S. assoc. with cerebral arteriosclerosis with psychotic reaction, plus alcoholism							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Day 19 Year 1960 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital, Sykesville, Md.	
20f. (City or town) Springfield Hospital, Sykesville, Md.				20g. (County) Frederick Co.			
20h. (State) Md.				20i. (Country) U.S.A.			
21. I certify that (I) (this hospital) attended the deceased from July 24, 1952 , to February 8, 1960 , that (I) (we) last saw the deceased alive on February 8, 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				22b. DATE 2/9/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL CREMATION, (Specify) Burial		23b. DATE THEREOF 2-11-60		23c. NAME OF CEMETERY OR CREMATORY Church of Brethern Com. Rocky Ridge, Fred. Co.		23d. LOCATION (City, town, or county) (State) Frederick Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Egan				ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR FEB 12 '60	
						25b. REGISTRAR'S SIGNATURE S. K. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

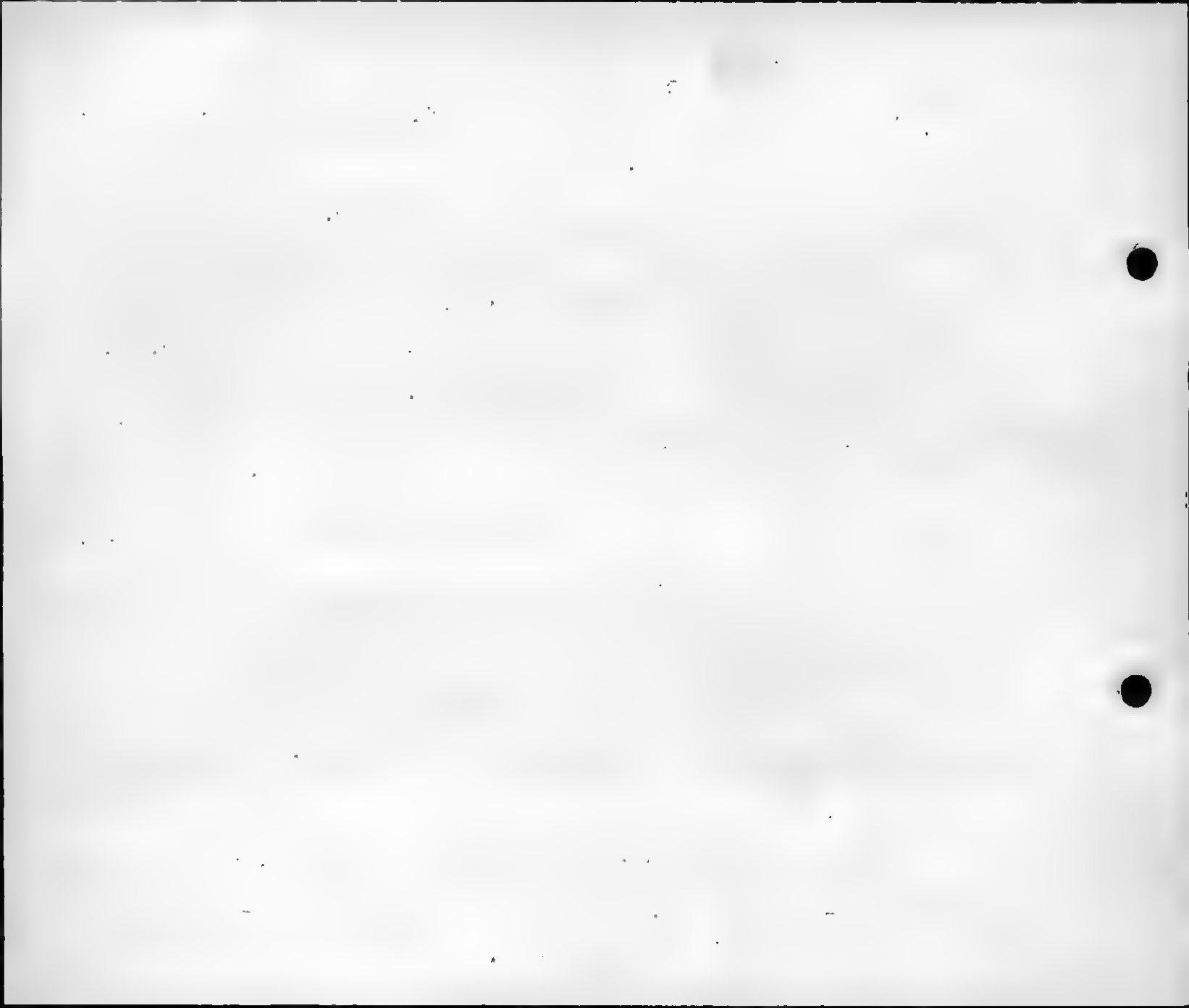
VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01852

1859

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grimesville</u>		c. LENGTH OF STAY IN 1b <u>27 hrs. 26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Conrad</u> Middle <u>Drew</u> Last <u>Shafer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 27, 1902</u>
9 AGE (In years lost birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	IF UNDER 24 HRS Hours <u>7</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Shafer</u>		14. MOTHER'S MAIDEN NAME <u>Mattie B. Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Springfield Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Pulmonary edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Day</u> <u>Years</u> <u>Hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia Praecox</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 20, 1954</u> to <u>Feb. 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7, 1960</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edmund Lusthaus</u>		22b. DATE SIGNED <u>2/8/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Springfield, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-11-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Frederick-Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. J. G. Jones</u>		25a. REC'D BY REGISTRAR <u>Home Frederick-Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Carla S. Jones</u>		25c. DATE <u>FEB 15 '60</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester, R.D. 1	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RES. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carroll Middle David Last Shaffer		4. DATE OF DEATH Month February Day 11 Year 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 03 Days 00	IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manchester		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John W. Shaffer		14. MOTHER'S MAIDEN NAME Carrie C. Shaffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes World War I		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 219-12-0888	
17. INFORMANT Carrie C. Shaffer Manchester Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot Gun Blast of Head DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anxiety-Depression	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 12 Gauge shot gun in mouth. Pulled trigger.		20c. TIME OF INJURY Month, Day, Year Feb. 11, 1960	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Manchester		(County) Carroll	
(State) Md		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE M.C. Porterfield		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.C. Porterfield, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Act. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/11/60	
22a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		22b. DATE THEREOF 2/13/60	
22c. NAME OF CEMETERY OR CREMATORY Manchester Cemetery		22d. LOCATION (City, town, or county) (State) Manchester, Carroll Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick Bucher Hammer		24. REC'D BY REGISTRAR Feb 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RURAL c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 140		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster RURAL d. STREET ADDRESS R.D.#2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR (EDWARD) SUTHARD First Middle Last		4. DATE OF DEATH February 8 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1916 9. AGE (In years last birthday) 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Nursery	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisah Suthard		14. MOTHER'S MAIDEN NAME Estell Heflin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 218-128352	
17. INFORMANT Laura Smith Suthard, Westminster, Md. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 716x FRACTURE of SKULL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH -	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident - collision	
20c. TIME OF INJURY 6:40 am 2-8 1960		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 140 - Westminster Carroll Md 20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marshall EXAMINER'S NAME (Type) JAMES T. MARSH		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		22d. LOCATION (City, town, or county) (State) York Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz, Winfield, Maryland ADDRESS		24a. REC'D BY REGISTRAR FEB 11 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE SIGNED 2-8-60	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

24.

CERTIFICATE OF DEATH

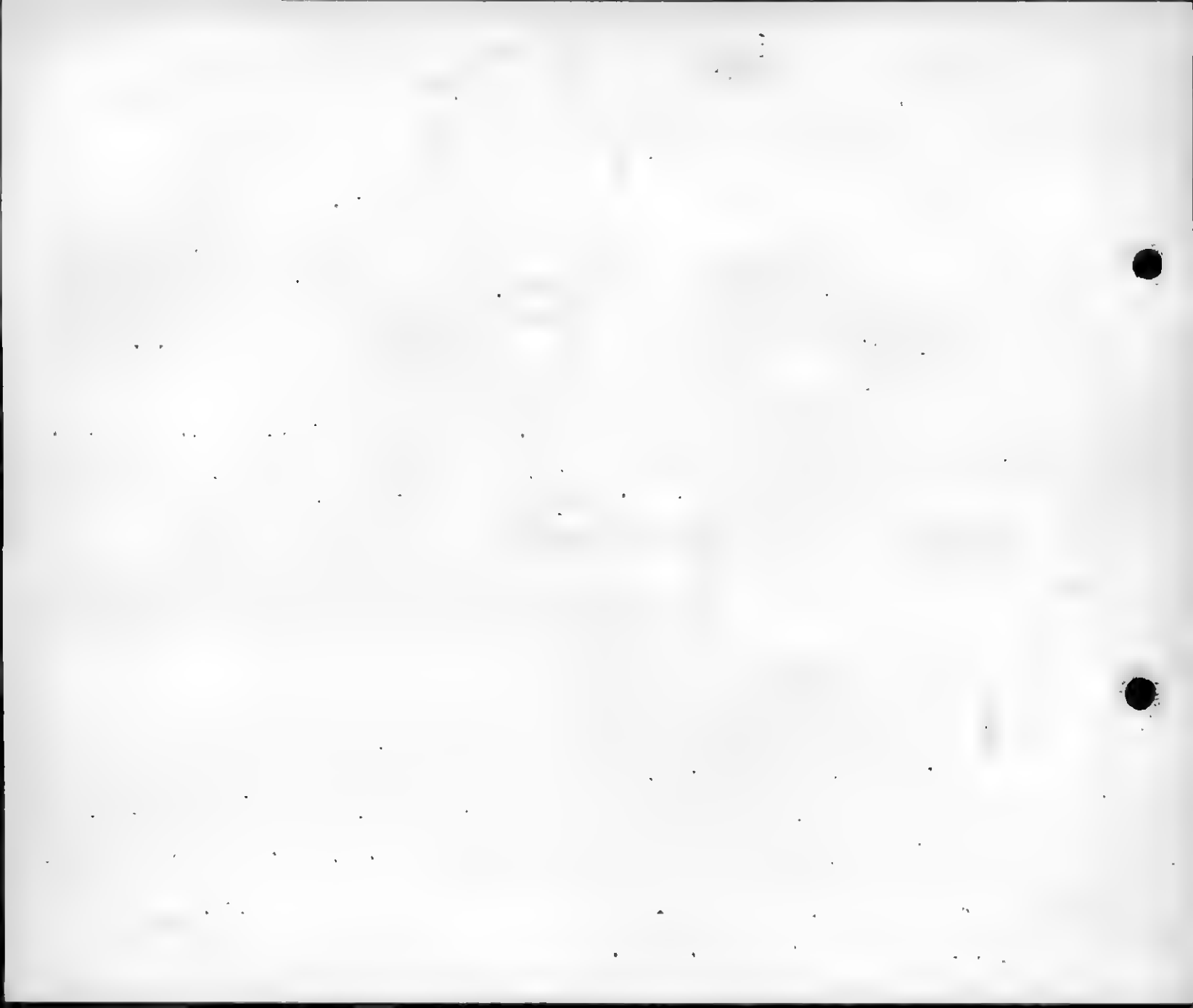
1862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 2 Months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Nursing Home		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission), a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon d. STREET ADDRESS 119 Central Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara Taylor First Middle Last		4. DATE OF DEATH February 7, 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1873 9. AGE (In years at birthday) 86 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. ADDRESS Geo. Kent Bellows, 119 Central Ave. Glyndon, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis - Decompensating 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertension & arteriosclerosis DUE TO (c) 2 yrs INTERVAL BETWEEN ONSET AND DEATH years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1930 to 2-7-1960 , that I last saw the deceased alive on 2-6-1960 , and that death occurred at 6 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Spaffell M.D.		DATE SIGNED 2-8-60	
PHYSICIAN'S NAME (Type) James G. Spaffell		ADDRESS (Street, City or town, state) Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR FEB 10 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

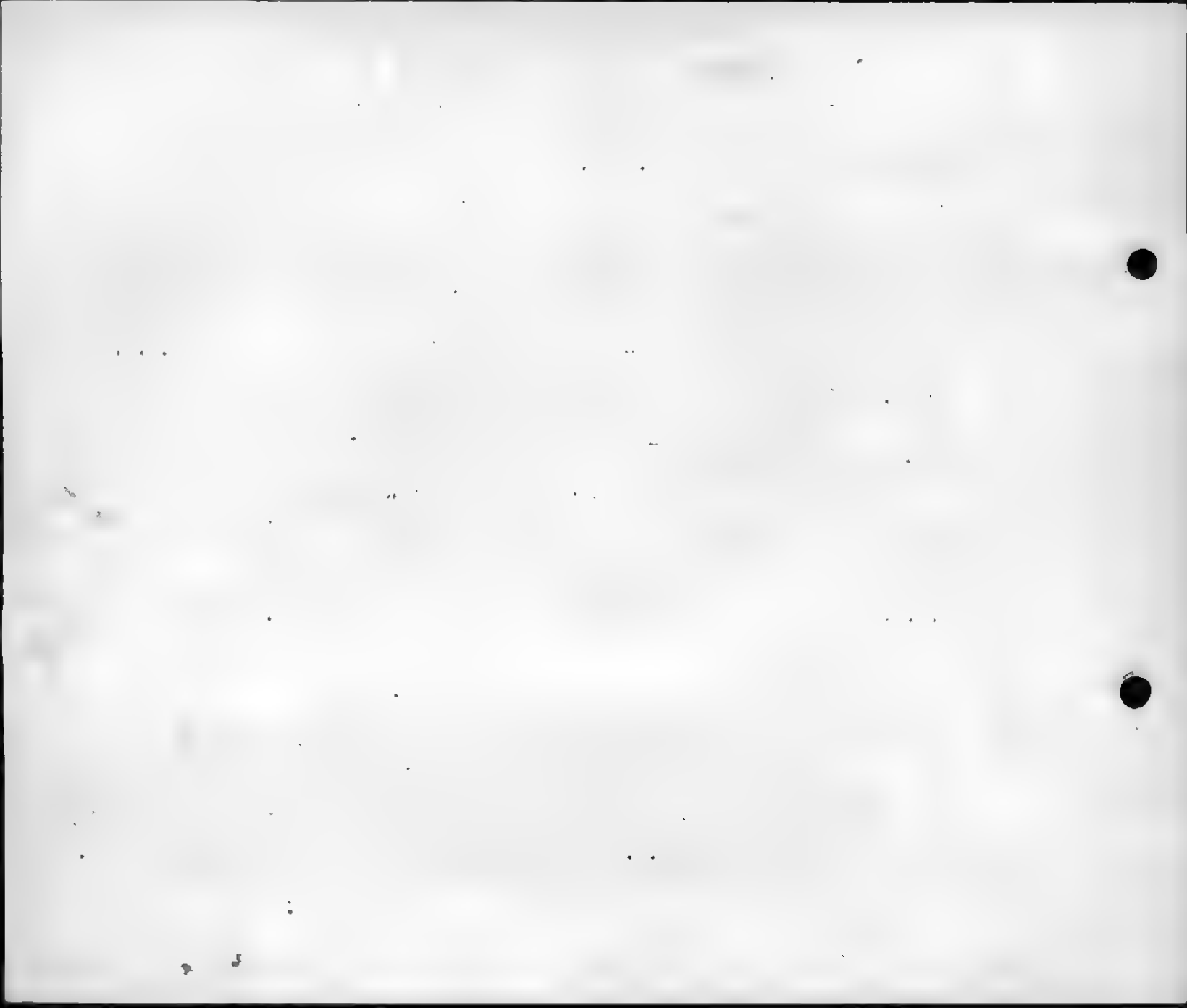
1863

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1863
CERTIFICATE OF DEATH

01856

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs. 9mos. 24days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Robert Middle Taylor Last Taylor				4. DATE OF DEATH Month February Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1931	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months 07 Days X Hours 00 Min 00		IF UNDER 24 HRS. Months 00 Days 00 Hours 00 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ira H. Taylor				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INTERMENT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced, active 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with birth trauma with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 25, 1956 to February 19, 1960 , that (I) (we) last saw the deceased alive on February 18, 1960 , and that death occurred at 1:40AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				22b. DATE 2/19/60		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield Hospital, Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-22-60		23c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery, Baltimore, Md.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				25a. REC'D BY REGISTRAR Pipes - 8		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



FOR STATE
HEALTH DEPT.

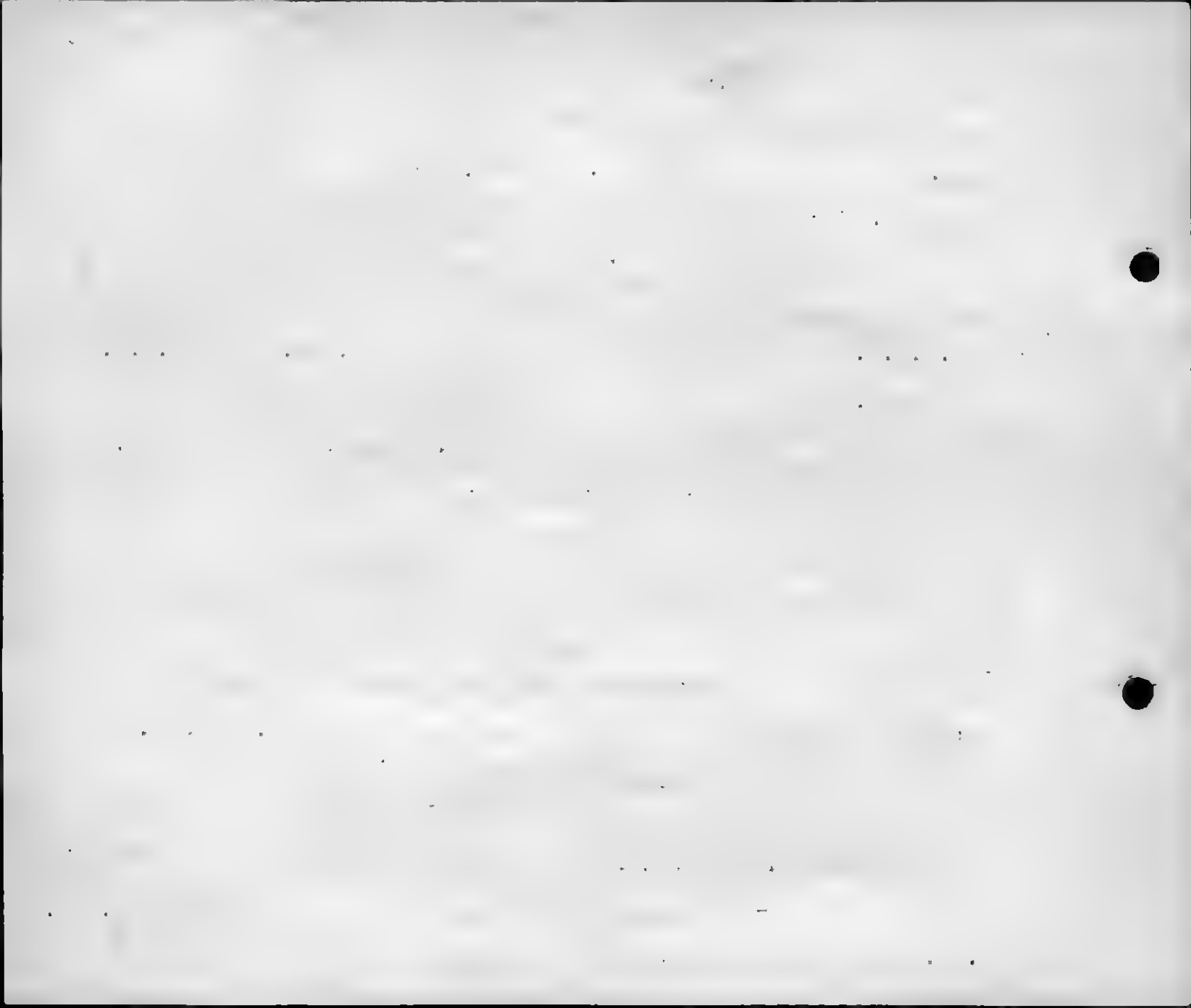
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, any delay is necessary, any delay is necessary. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01857

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN b 6 yrs.		2. USUAL RESIDENCE (Where deceased lived, if installed on: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		d. STREET ADDRESS home - Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JAMES		First M.		Middle THOMAS		Last		4. DATE OF DEATH February 21 1960		Month 21		Day 1960		Year							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1938		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.A.F.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George C. Thomas		14. MOTHER'S MAIDEN NAME Justa Witherspoon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of discharge) Yes 6-57 to 60		16. SOCIAL SECURITY NO. 214-36-0389		17. INFORMANT George C. Thomas, Mt. Airy, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 891.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Carbon monoxide poisoning		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Asphyxiated while working on car in closed garage		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Asphyxiated while working on car in closed garage		20c. TIME OF INJURY Month, Day, Year 2/21/1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage		20f. (City or town) (County) (State) Mt. Airy, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE R. Fisher		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/22/60		EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 26-60		22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or country) (State) Mt. Airy, Carroll Co. Md.		23. FUNERAL DIRECTOR C. M. WALTZ,		ADDRESS WINFIELD, MARYLAND		24a. REC'D BY REGISTRAR FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume		DATE					

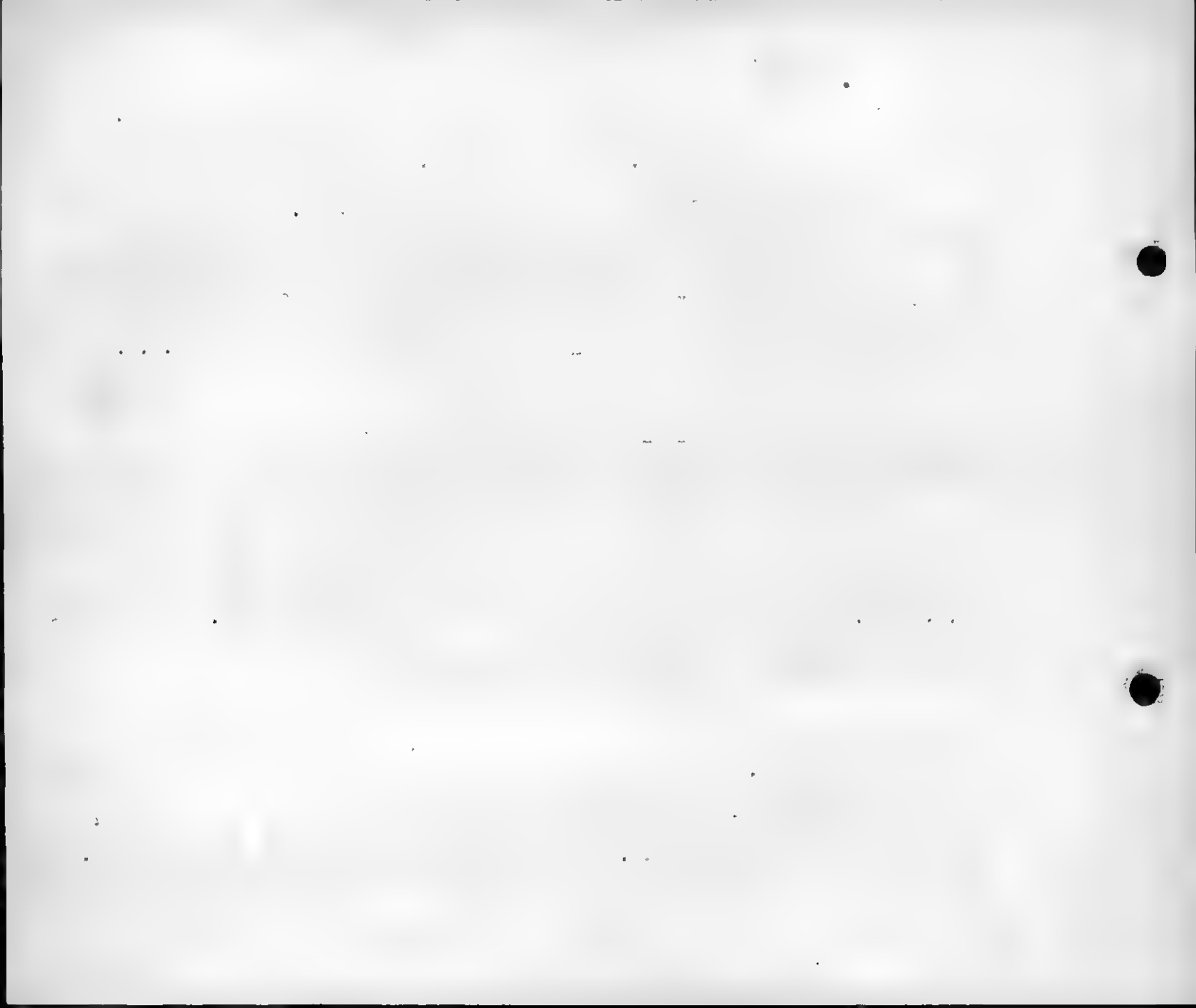


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1864
CERTIFICATE OF DEATH

01858

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3mos. 2days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maude Middle Barroll Last Compton Towson				4. DATE OF DEATH Month February Day 23 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 9, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aide				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Compton				14. MOTHER'S MAIDEN NAME Catherine Carroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-20-6772		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.P.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 21, 1959 to February 23, 1960 , that (I) (we) last saw the deceased alive on Feb. 22, 1960 , and that death occurred at 2:55 AM from the causes and on the date stated above							
22a. SIGNATURE <i>Edmund Lusthaus</i> M.D.				22b. DATE SIGNED 2/23/60		22c. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.	
22d. ADDRESS Springfield Hospital, Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-25-60		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town, or county) (State) BALTO, CO.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Chumley</i>				25a. REC'D BY REGISTRAR FEB 24 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



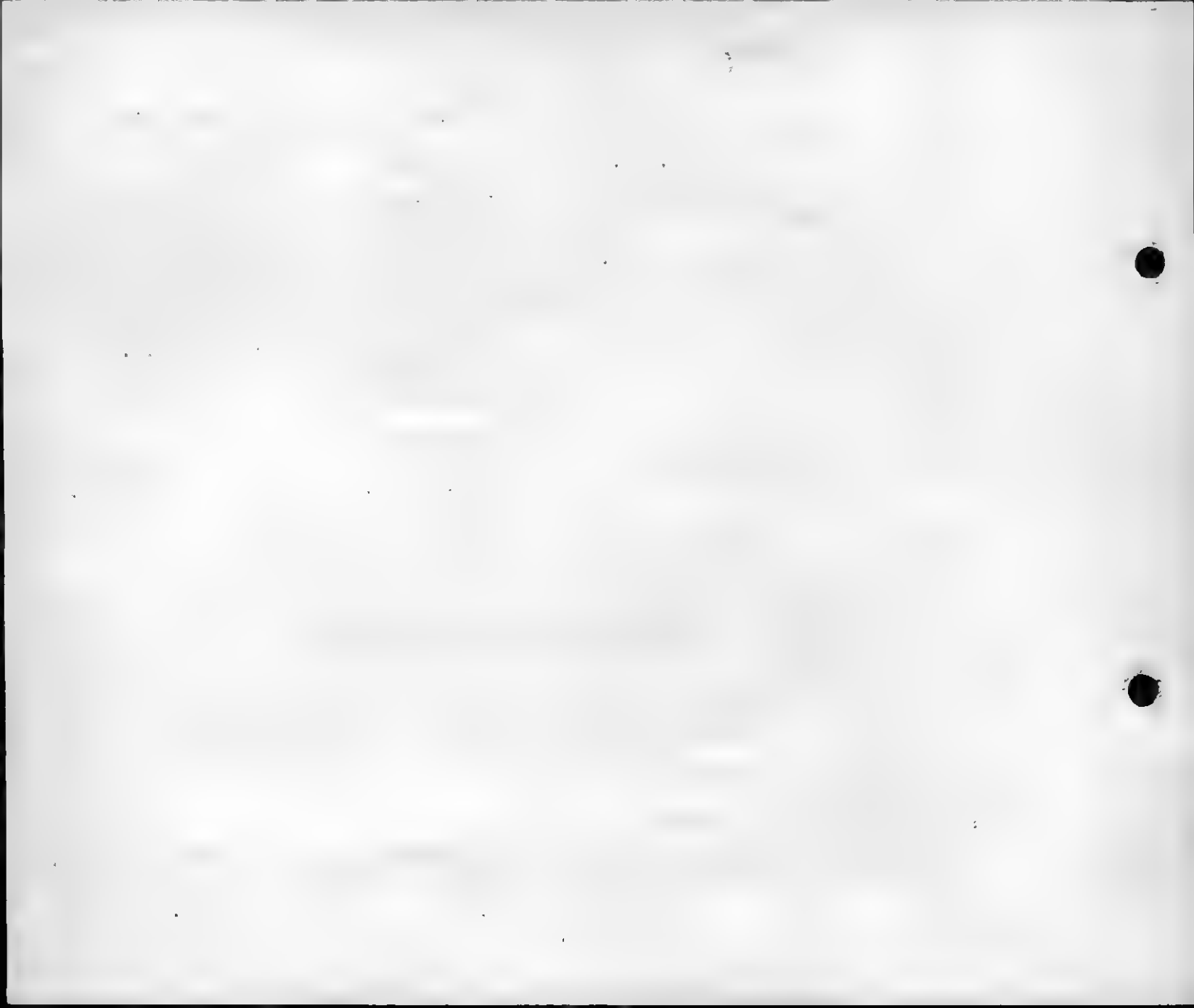
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR ATS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01859

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 30yr.6mo.8days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3103 Mareco Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First James Middle T. Last Tuohy			4. DATE OF DEATH Month February Day 9 Year 19 60		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH November 6, 1907		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months 3 Days 01 Hours 4 IF UNDER 24 HRS: Hours 4 Min.	
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Tuohy			
14. MOTHER'S MAIDEN NAME Annie Sullivan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO None		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Constitutional Psychopathic Personality					
19. INTERVAL BETWEEN ONSET AND DEATH Years.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 31, 19 29 to February 8, 19 60 that (I) (we) last saw the deceased alive on February 8, 19 60 , and that death occurred 4:15 A.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Agustin del Campo</i> 22c. PHYSICIAN'S NAME (Type) Agustin del Campo		22b. DATE SIGNED 2/9/60		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
23d. LOCATION (City, town, or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane			
25a. REC'D BY REGISTRAR FEB 11 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1866 CERTIFICATE OF DEATH

01860

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6mo. 17days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4315 Harford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry Franklin Wagner				4. DATE OF DEATH Month Day Year February 11 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1883	
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 76		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee B.&O.R.R.				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Herman Wagner				14. MOTHER'S MAIDEN NAME Amelia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -		17. INFORMANT Springfield Hospital records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) Bronchopneumonia							INTERVAL BETWEEN ONSET AND DEATH years years days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction							19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital, Sykesville, Md.		20g. (County) Baltimore, Md.		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from July 24, 1959 to February 11, 1960 , that (I) (we) last saw the deceased alive on February 10, 1960 and that death occurred at 10:56 A.M. the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				22b. DATE SIGNED 2/11/60		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield State Hospital, Sykesville, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE 2/11/60	
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 2-15-60		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				25a. REC'D BY REGISTRAR DATE FEB 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

23a. BURIAL, CREMATION REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

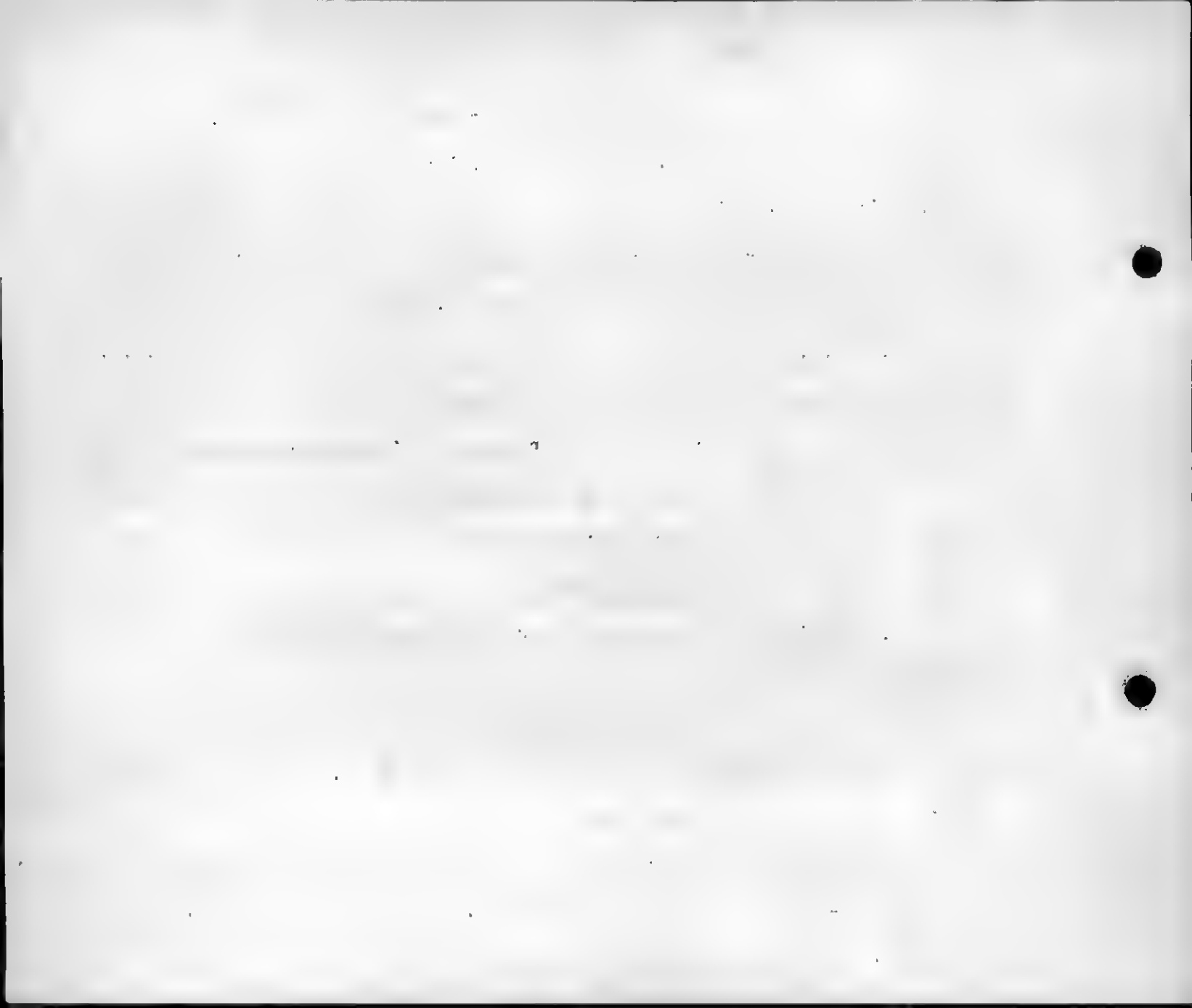
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1867

CERTIFICATE OF DEATH

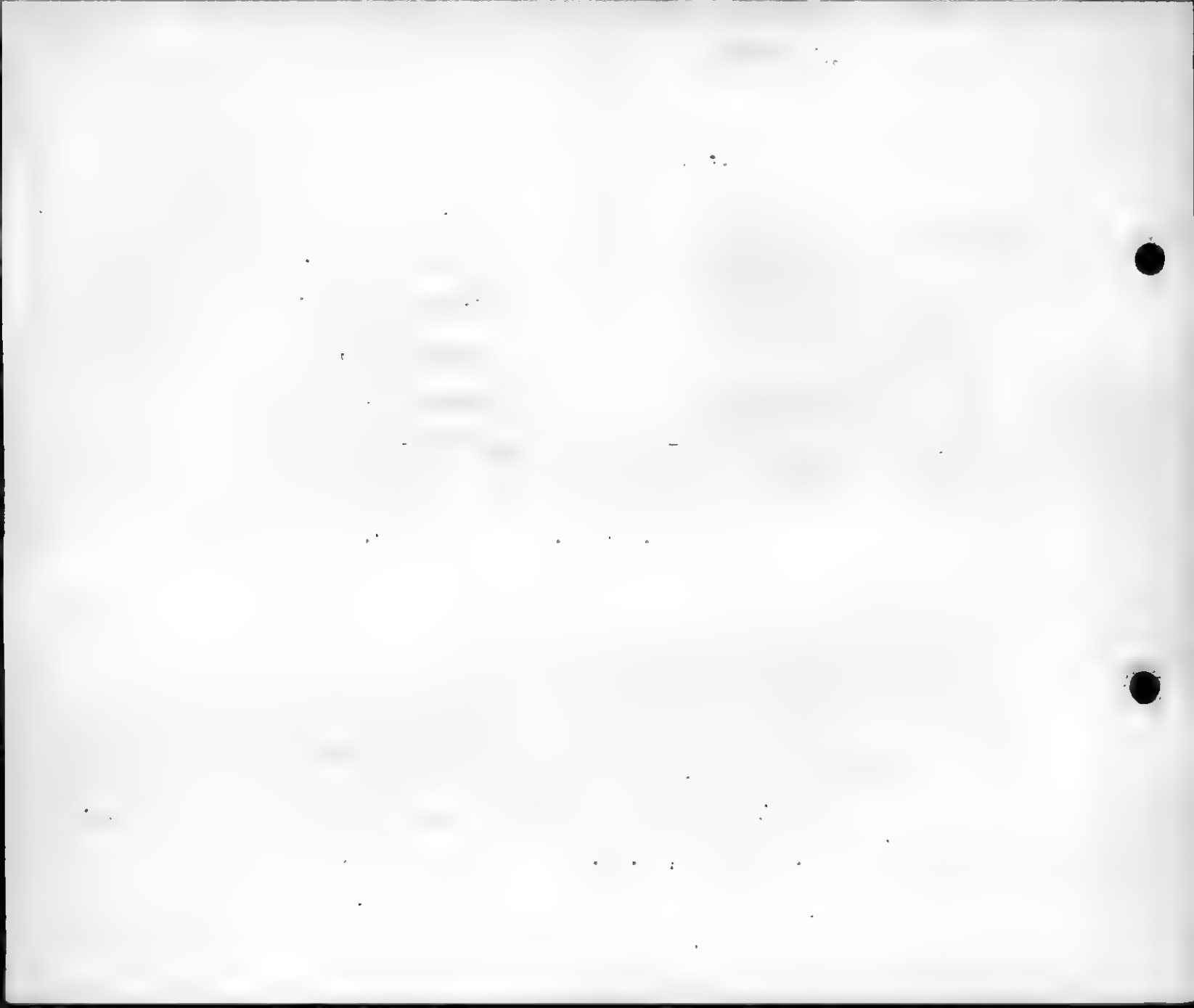
Reg. Dist. No. 74

01867

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 230 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS Route 1, Box 39			
3. NAME OF DECEASED (Type or print) First Minnie Middle Grace Last Webb				4. DATE OF DEATH Month February Day 8 Year 19 60			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1890 1899	9. AGE (In years last birthday) 69 60 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Federalburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Hubbard				14. MOTHER'S MAIDEN NAME Eliza Webb Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-01-9432		INFORMANT Grace Webb - Same as patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far adv. bilat. pulmonary tbc. & cavity right DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month June Day 23 Year 19 59 Hour 8 a. m. 35 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June 23 , 19 59 , to February 8 , 19 60 that I last saw the deceased alive on February 8 , 19 60 , and that death occurred at 8:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgars M. Maculans M. D.		M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 2-8-60	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		HOSPITAL Henryton State Hospital					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 13, 1960	22c. NAME OF CEMETERY OR CREMATORY Johns Cemetery		22d. LOCATION (City, town, or county) (State) Near Preston, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton, Jr.		ADDRESS Federalburg, Maryland		24a. REC'D BY REGISTRAR FEB 15 '60	24b. REGISTRAR'S SIGNATURE Arthur E. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

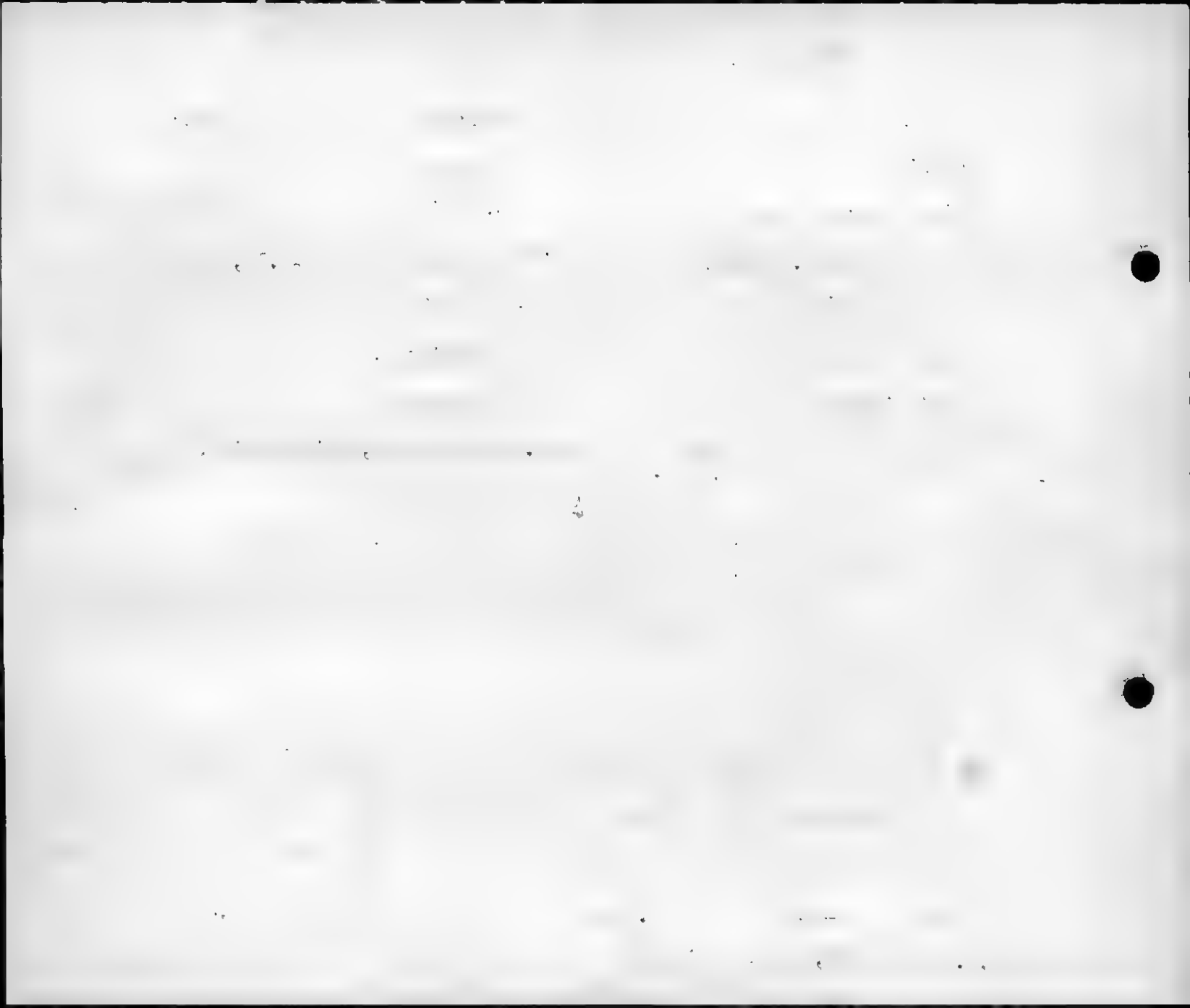
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1868
CERTIFICATE OF DEATH

01862

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weitzel Nursing Home				d. STREET ADDRESS Clarksville			
3. NAME OF DECEASED (Type or print) WILLIAM H. WIDERMAN First Middle Last Widerman				4. DATE OF DEATH Feb. 18, 1960 Month Day Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1876	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Levi Widerman			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Frank Cameron, Ellicott City, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure, Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized, bronchial pneumonia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1959 18 Feb 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to 18 Feb , that (I) (we) last saw the deceased alive on 18 Feb 1960 and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Howard E. Hall				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 18 Feb 60	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Agnewville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-20-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City, town, of county) (State) Randallstown, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				25a. REC'D BY REGISTRAR DATE FEB 23 '60		25b. REGISTRAR'S SIGNATURE William S. Kraus	



1863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6 yrs. 26 dys.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle - Last Williams		4. DATE OF DEATH Month 2 Day 15 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/93
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. Joshua B. Whaling		14. MOTHER'S MAIDEN NAME Alice V. Beardsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Informant Hospital records, Springfield State Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 305X IMMEDIATE CAUSE (a) Asphyxia due to obstruction of both bronchi by food. INTERVAL BETWEEN ONSET AND DEATH hours DUE TO (b) Pulmonary congestion and edema. hours DUE TO (c) Pick's Disease of the brain. years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 18 , 19 58 , to Feb. 15 , 19 60 , that I last saw the deceased alive on Feb. 15 , 19 60 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 2-16-1960 ACTUAL SIGNATURE Konstantin Weber M.D. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/60	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR DATE FEB 19 '60	
ADDRESS Barnesville Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10/10

NOV 10 1964

1021

[Faint, mostly illegible text covering the majority of the page, possibly a letter or report.]

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Burial	Mar 2-60	Lutheran	Manchester Conn	CT
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Edw Chipton		Hampstead NY	DATE MAR 2 '60	Arthur L. Fraser

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